ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

Companion Document and Transaction Specifications for HIPAA 837 Encounter Transactions

Version 5.1
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1 Introduction

1.1 Document Purpose

Companion Documents

HIPAA Transaction Companion Documents are available to electronic trading partners (health plans, program contractors, providers, third party processors, and billing services) to clarify information on HIPAA-compliant electronic interfaces with AHCCCS. The following Companion Documents are being produced:

- 834 Enrollment and 820 Capitation Transactions
- 270 Eligibility Request and 271 Eligibility Response Transactions
- 837 Claim Transactions
- 835 Electronic FFS Claims Remittance Advice Transaction
- 276 Claim Status Request and 277 Claim Status Response Transactions
- *837 Encounter Transactions*
- 277 Unsolicited Claim Status Transaction (Encounters)

HIPAA Overview

The Administrative Simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA, Title II) require the federal Department of Health and Human Services to establish national standards for electronic health care transactions and national identifiers for providers, health plans, and employers. The Act also addresses the security and privacy of health data. The long-term purpose of these standards is to improve the efficiency and effectiveness of the nation's health care system by encouraging widespread use of standard electronic data interchanges in health care.

The intent of the law is that all electronic transactions for which standards are specified must be conducted according to the standards. These standards were reviewed through a process that included significant public and private sector input prior to publication in the Federal Register as Final Rules with legally binding implementation time frames.

Covered entities are required to accept transmissions in the standard format and must not delay a transaction or adversely affect an entity that wants to conduct standard transactions electronically. For HIPAA, both AHCCCS and its health plans are covered entities.

Document Objective

This Encounter Companion Document provides information related to electronic submission of 837 Encounter Transactions to AHCCCS by contracted health plans. Three distinct encounter transaction formats are documented:

- 837 Professional
- 837 Dental
- 837 Institutional

For each of these formats, this Companion Guide tells health plans how to prepare and maintain a HIPAA compliant encounter interface, including information on populating encounter data elements for submission to AHCCCS.

Intended Users

Companion Documents are intended for the technical staffs of health plans and other entities that are responsible for electronic transaction exchanges. They also offer a statement of HIPAA Transaction and Code Set Requirements from an AHCCCS perspective.

Relationship to HIPAA Implementation Guides

Companion Documents are intended to supplement the HIPAA Implementation Guides for each of the HIPAA transactions. Rules for data format, content, and field values can be found in the Implementation Guides. This document describes the technical interface environment with AHCCCS in terms of data and processing implications for AHCCCS trading partners. Operational information involving connectivity requirements, protocols, and electronic interchange procedures is covered in other documents that are available from the AHCCCS Information Services Division (ISD) Customer Support Center. This Companion Document provides specific information on the fields and values required for transactions that are sent to or received from AHCCCS.

Companion Documents are intended to supplement but not to replace the standard Implementation Guides for each HPIAA Transaction Set. Information in Companion Documents is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

Disclaimer

This Companion Document is a technical document describing the specific technical and procedural requirements for interfaces between AHCCCS and its trading partners. It does not supersede either the health plan contracts or the specific procedure manuals for various operational processes. If there are conflicts between this document and health plan contracts or operational procedure manuals, the contract or procedure manual will prevail.

Substantial effort has been taken to minimize information conflicts. However, AHCCCS, the Information Services Division, or its employees will not be liable or responsible for any errors or expenses resulting from the use of information in this document. If you believe there is an error in the document, please notify the AHCCCS Information Services Division immediately.

1.2 Contents of this Companion Document

Introduction	Section 1 provides general information on Companion Documents and HIPAA and outlines the information to be included in the remainder of the document.
Transaction Overview	Section 2 provides an overview of the transaction or transactions included in this Companion Document including information on: ▪ The purpose of the transaction(s) ▪ The standard Implementation Guide for the transaction(s) ▪ Replaced and impacted AHCCCS files and processes ▪ Transmission schedules
Technical Infrastructure	Section 3 provides a brief statement of the technical interfaces required for trading partners to communicate with AHCCCS via electronic transactions. The AHCCCS Encounter Reporting User Manual provides information on file names and procedures used in encounter submission. See especially Chapter Two, Encounter Reporting Guidelines.
Transaction Standards	Section 4 provides information relating to the transaction(s) in this Companion Document including: ▪ General HIPAA transaction standards ▪ Testing criteria and procedures ▪ Front end edits applicable to incoming transactions ▪ Procedures for generating and responding to required acknowledgment transactions ▪ Procedures for handling rejected transmissions and transactions
Transaction Specifications	Section 5 provides specific information relating to the transaction(s) in this Companion Document including: ▪ A statement of the purpose of transaction specifications between AHCCCS and other covered entities ▪ AHCCCS-specific data requirements for the transaction(s) at the data element level Transaction Specifications define in detail how HIPAA Transactions are formatted and populated for exchanges with AHCCCS.

2. 837 Encounter Transactions

2.1 Transaction Overview

Encounter Submission

The 837 Encounter Transaction has three separate formats for professional, dental, and institutional claims or encounters. Each of the formats has hundreds of data elements that describe medical services. Encounter submission by health plans and encounter receipt and processing by AHCCCS are not changed by HIPAA mandates. What have changed significantly are encounter formats and code set requirements. AHCCCS "New Day" Encounters will now be submitted in 837 formats. New Day Encounters are encounters submitted to AHCCCS for the first time. They sometimes void or replace previously adjudicated encounters but they cannot correct or release encounters that are still in process.

In the HIPAA compliant environment, AHCCCS accepts encounters in the 837 formats and relies on a newly installed translator to bring them into its Prepaid Medical Management Information System (PMMIS). Once in PMMIS, the AHCCCS encounter correction process remains unchanged from the pre-HIPAA environment.

Encounter Processing

AHCCCS will use the Unsolicited 277 Encounter Status Transactions to inform submitting health plans of the status of each encounter. Encounter and service line status codes on the U277 Transaction are translated from codes used by PMMIS. "Pended" encounters in need of correction continue to be handled by correction procedures specific to AHCCCS and its health plans.

Processes Replaced or Impacted

Replaced Processes

- Pre-HIPAA Electronic New Day Encounter File

Impacted Processes

- Receipt of encounters from contracted health plans
- Notification to health plans of encounter statuses with Unsolicited 277 Encounter Status Transactions

The impacted processes will continue to function but will be changed so that they meet all X12N data and/or format compliance requirements.

2.2. Encounter Transactions

Purpose

Health plans pay claims from providers in their networks. AHCCCS pays health plans on a capitated per member per month basis with additional payments for high expenditure members via reinsurance. The Agency makes use of encounter data in capitation rate setting and in critical financial and utilization reports.

AHCCCS uses HIPAA compliant 837 Transactions for both fee for service claims and encounters. This Companion Document deals only with encounters.

Contracted health plans transmit 837 Encounter Transactions in batch mode through the AHCCCS File Transfer Protocol (FTP) Server. Batch submission accommodates large volumes of encounters from multiple health plans.

Standard Implementation Guides

The Standard Implementation Guides for Encounter Transactions are:

- 837 Health Care Claim: Professional (004010X098)
- 837 Health Care Claim: Dental (004010X097)
- 837 Health Care Claim: Institutional (004010X096)

For 837 Transactions, AHCCCS is incorporating all approved Addenda. Transmission Type Codes for production transactions that follow standards as modified by Addenda are:

- ASC X12N 837 Professional (004010X098A1)
- ASC X12N 837 Dental (004010X097A1)
- ASC X12N 837 Institutional (004010X096A1)

Related Specifications

In addition to 837 Encounter Transactions, AHCCCS is implementing Unsolicited 277 or U277 Encounter Status Transactions. AHCCCS sends U277 Transactions to encounter submitters in response to processed encounters with finalized or pended outcomes. Professional, dental, institutional, and drug encounters are included. The U277 Transaction has its own Companion Document.

3. Technical Infrastructure and Procedures

3.1 Technical Environment

AHCCCS Data Center Communications Requirements

Trading partners connect to AHCCCS by going from the Internet through a Virtual Private Network (VPN) Tunnel to the AHCCCS File Transfer Protocol (FTP) Server. In standard software-to-hardware VPN connections, VPN client software is installed and configured on each machine at the client site that requires FTP access. Cisco Systems Software to establish provider computers as VPN Clients is available from the sources documented in the AHCCCS electronic encounter submission document. Detailed information on FTP and VPN setups also appears in that manual.

Technical Assistance and Help

The AHCCCS ISD Customer Support Center provides technical assistance related to questions about electronic data submission or data communications interfaces. All calls result in Ticket Number assignment and problem tracking. Contact information is:

- **Telephone Number:** (602) 417-4451
- **Hours:** 8:00 AM – 5:00 PM Arizona Time, Mondays through Fridays
- **Information required for initial call:**
  - Topic of Call (VPN setup, FTP procedures, 837 Encounter Transaction, etc.)
  - Name of caller
  - Organization of caller
  - Telephone number of caller
  - Nature of problem (connection, receipt status, etc.)
- **Information required for follow up call(s):**
  - Ticket Number assigned by the Customer Support Center

3.2 Directory and File Naming Conventions

FTP Directory Naming Convention

The current structure on the FTP server is designed to provide logical access to all files, ease troubleshooting searches, and simplify security for account set ups and maintenance. Current FTP Directory file naming conventions are as follows:

FTP\HP Mnemonic\encounter\(HP ID IN\HP ID OUT)\(prod\test)

- HP Mnemonic – The 3-byte acronym assigned by AHCCCS.
- encounter – The default directory name indicating 837 Encounter Transactions.
- HP ID IN – The default directory name that includes the numeric Health Plan ID indicating inbound data.
- HP ID OUT – The default directory name that includes the numeric Health Plan ID indicating outbound data.
- prod – The default directory name indicating it is the production environment.
- test – The default directory name indicating it is the test environment.

File Naming Conventions

837 Encounter Transactions

For information on Incoming and Outgoing file formats, reference the Encounter Reporting User Manual available on the AHCCCS website (http://www.ahcccs.state.az.us./Publications/guides.asp).

TA1 Interchange Acknowledgement Transactions

Trading partners can use the TA1 Transaction to acknowledge receipt of transmissions or interchanges of X12 Transactions and to tell AHCCCS of problems in the ISA/IEA Interchange Envelope. Refer to Section 4.4, Acknowledgement Procedures, for additional information.

MMDDYY.000000000.TA1

- MMDDYY is the process date.
- 000000000 is the unique 9 character Interchange Control Number created for every file AHCCCS sends to the trading partner regardless of the transaction type.
- TA1 is the acknowledgement type.

997 Functional Acknowledgement Transactions

A 997 can be sent as an acknowledgement for each GS/GE Envelope or Functional Group of one or more transactions within the interchange or to report on some types of syntactical errors. Refer to Section 4.4, Acknowledgement Procedures, for additional information.

MMDDYY.000000000.997

- MMDDYY is the process date.
- 000000000 is the unique 9 character Interchange Control Number created for every file AHCCCS sends to the trading partner regardless of the transaction type.
- 997 is the acknowledgement type

824 Implementation Guide Reporting Transactions

For transmissions that are valid on the interchange level, the translator edits transactions and uses 824 Implementation Guide Reporting Transactions to report problems. Refer to Section 4.4, Acknowledgement Procedures, for additional information.

MMDDYY.000000000.824

- MMDDYY is the process date.
- 000000000 is the unique 9 character Interchange Control Number created for every file AHCCCS sends to the trading partner regardless of the transaction type.
- 824 is the acknowledgement type.

3.3 BBA (Balanced Budget Act) Data Certification Process

Introduction

Before a contractor may submit encounter data, AHCCCSA requires the completion of certain agreements, authorizations and control documents. In addition, a contractor must submit a concurrent attestation certification indicating that, based on best knowledge, information and belief, data submitted to AHCCCSA is accurate, complete and truthful. These documents are as follows:

Form 1: Health Plan/Program Contractor Encounter Submission Notification and Transmission Submitter Number (TSN) Application (Refer to Appendix A.1 for more information.)

Form 2: Electronic Data Interchange Agreement Form (Refer to Appendix A.2 for more information.)

Form 3: Data Certification Email – concurrently submitted with each file (Refer to Appendix A.3 for more information.)

Purpose of Control Documents

AHCCCSA requires control documents for legal purposes. They provide:

- A supplemental, contractual agreement specific to AHCCCSA and the contractor for the submission, acceptance and processing of encounter data;
- AHCCCSA with the names and signatures of contractor representatives authorized to submit encounter data; and
- Authorization for AHCCCSA to process the information on encounter data files, and verifies that it is accurate, complete, and truthful.

Note that if a contractor intends to change vendors (this would include termination or change of a contract with the vendor), the contractor must notify the encounter unit prior to the change. AHCCCSA will then require completion of new control documents authorizing encounter submissions.

Testing Process for New Contractors

In order to ensure the success of encounter data submissions, new contractors must go through a testing phase before submitting official encounter data to AHCCCSA. Prior to beginning the testing phase, contractors must have provided all necessary control documents to the AHCCCS Encounter Manager. New contractors are encouraged to begin this process as soon as possible after the award of a contract. Once the encounter unit receives the necessary authorizations, AHCCCSA will assign a Transmission Submitter Number (TSN) and notify the contractor. AHCCCSA will also schedule a training session for the contractor and/or designated subcontractor during which the testing process will be reviewed.

Technical assistance is available from encounter unit staff during the testing period. When AHCCCSA verifies that a contractor has successfully completed the testing process, the contractor will be allowed to begin submitting encounters.

Control Document Instructions

Instructions for all encounter submission-related forms or data certification email are available from the encounter unit. Samples of these are included and discussed in Appendix A.

Detailed Data Flow

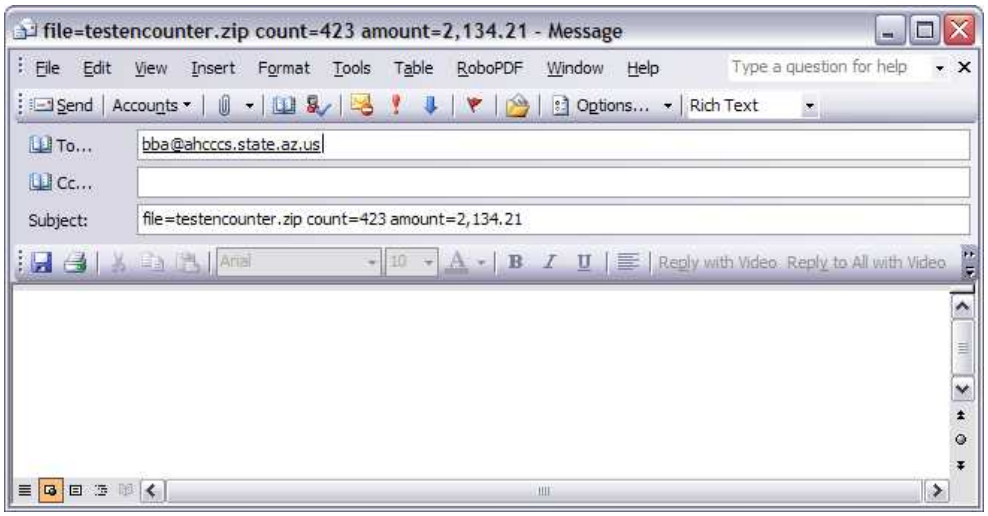
AHCCCS requirements for an automated approach to data certification for encounters transactions are described below:

Email Contents

Contents of Email

- Send emails to the following address: bba@ahcccs.state.az.us
- Subject will have filename, dollar amount in the file, and claim count
  - The filename will be the file that is delivered to AHCCCS (if it is zipped when delivered, then the zipped file will be the one reported)
- The body of the email will be the same text as what is currently being faxed to AHCCCS (refer to encounter manual for exact verbiage)

Sample Subject Line



Subject Line Characteristics

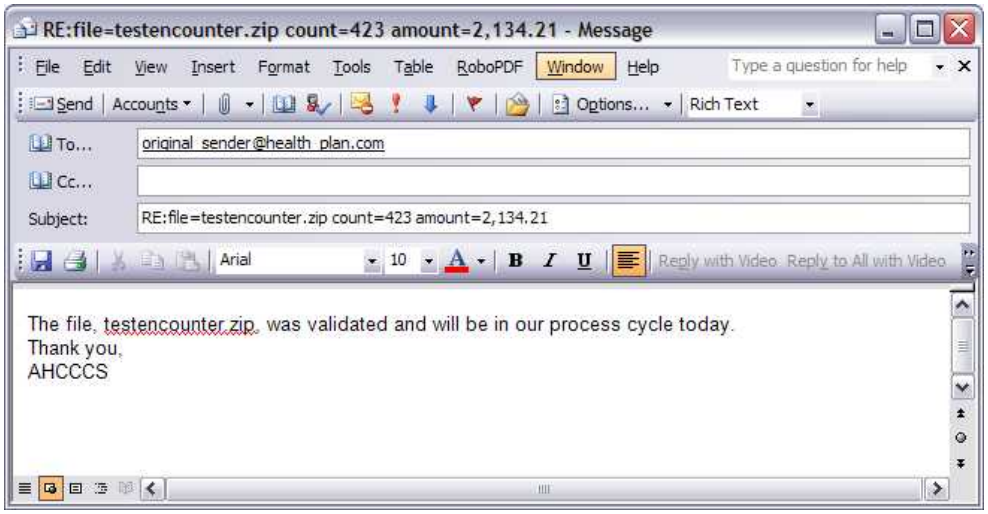
- Not case sensitive
- Additional spaces are optional
- Commas are optional on count and amount
- Dollar sign is optional on amount
- Order of required objects (‘filename=‘, ‘amount=‘, and ‘count=‘) in subject not necessary, but all three have to be present
- No abbreviations of the required objects

Email Responses

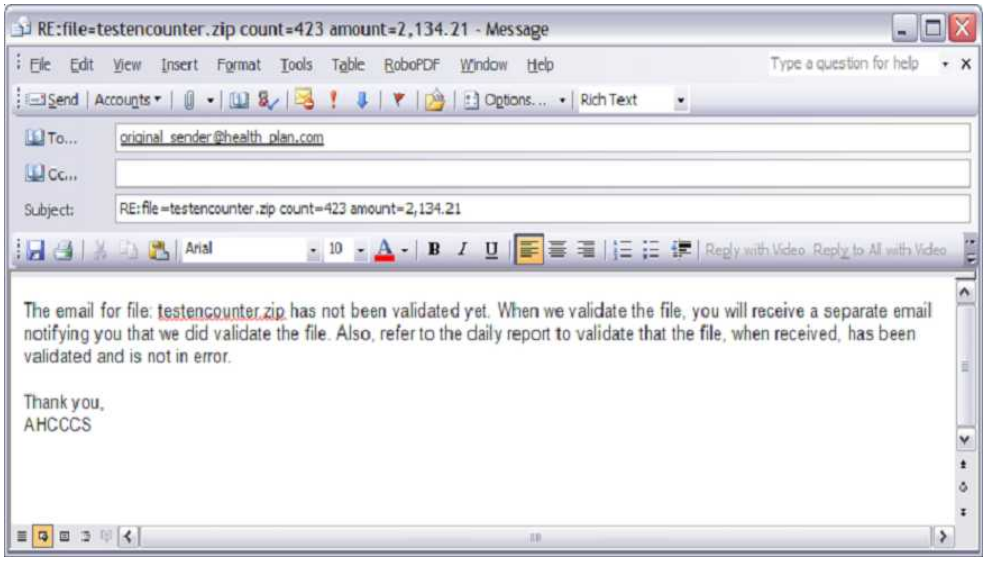
When an email is received, there will be one of 4 emails in response to the sender

1. Positive Response
   Email validated file that was found and the encounter file will be processed.
2. Not Processed Yet
   Email came from an unauthorized email address
3. Count / Amount Invalid
   Email was received, but AHCCCS has not validated the file yet against the filename in the subject line. (followed by #1)
4. Subject Line Invalid
   Email was received, but the amount or count does not match the file as validated against the objects in the subject line.

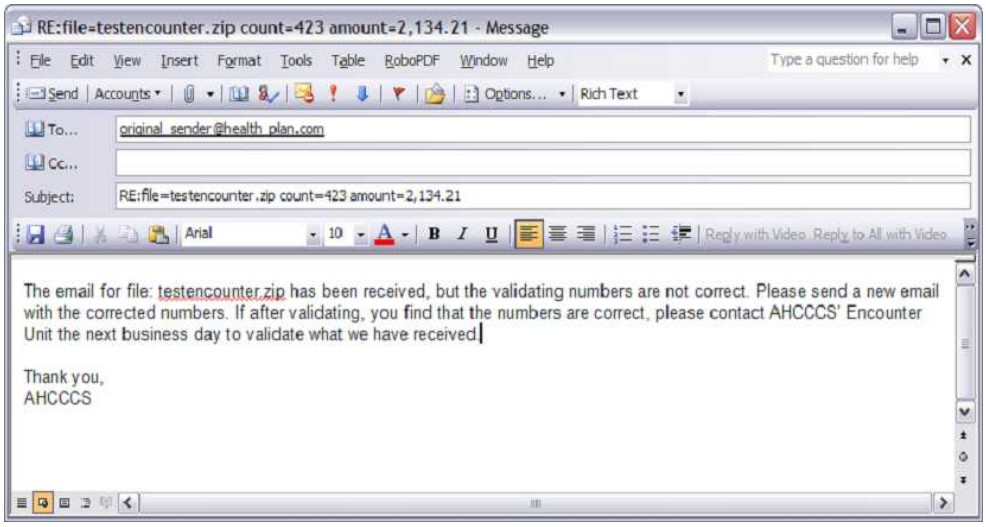
Sample "Positive" Response



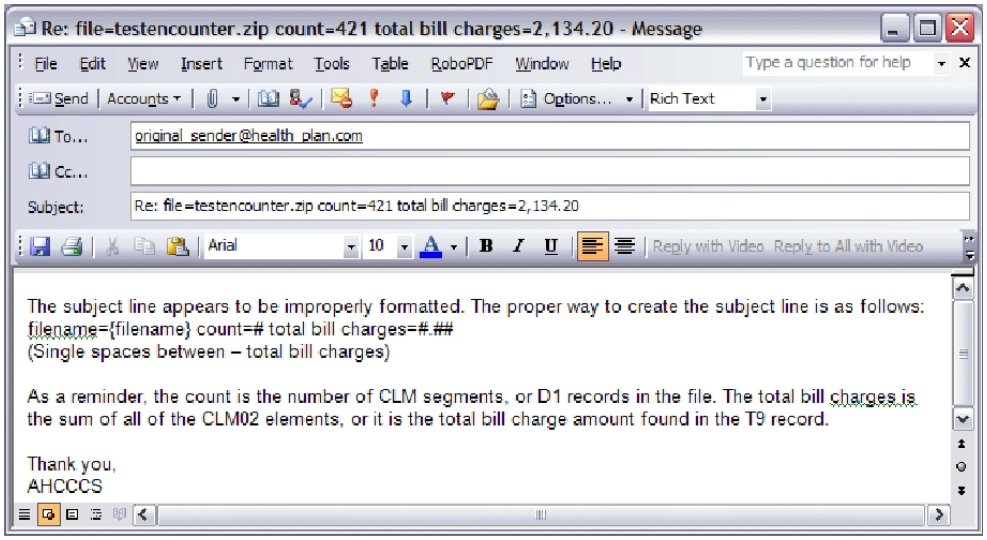
Sample "Not Processed Yet" Response



Sample "Count/Amount Invalid" Response



Sample "Subject Line Invalid" Response

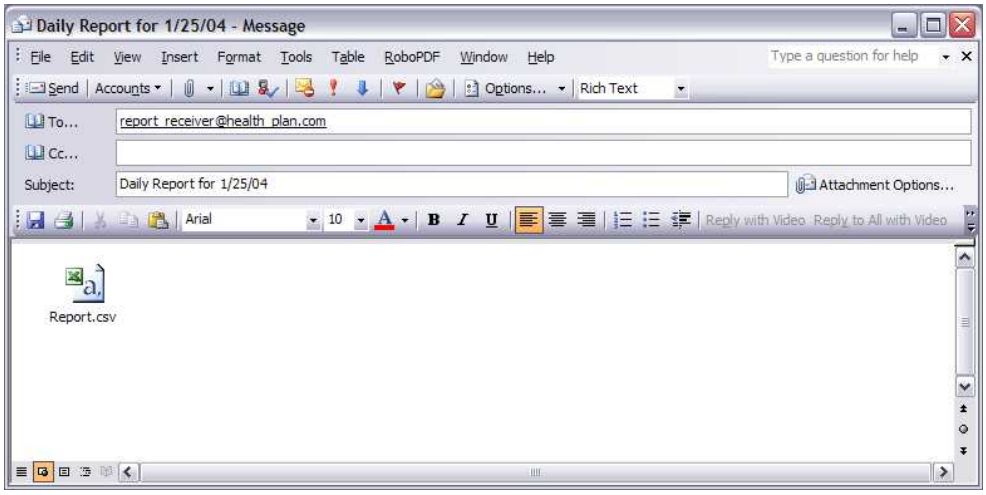


Email Reporting Samples

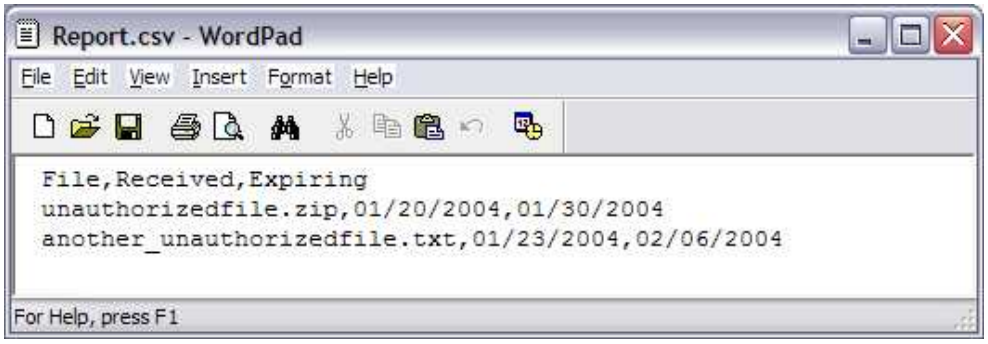
On a daily basis, a report is emailed with the list of files that are not yet authorized.

- Report delivered daily.
- Report delivered to those who are designated to receive the report.
- Report contains only non-expired files with the following information:
  - File name that was received.
  - When the file was received.
  - When the file will expire.

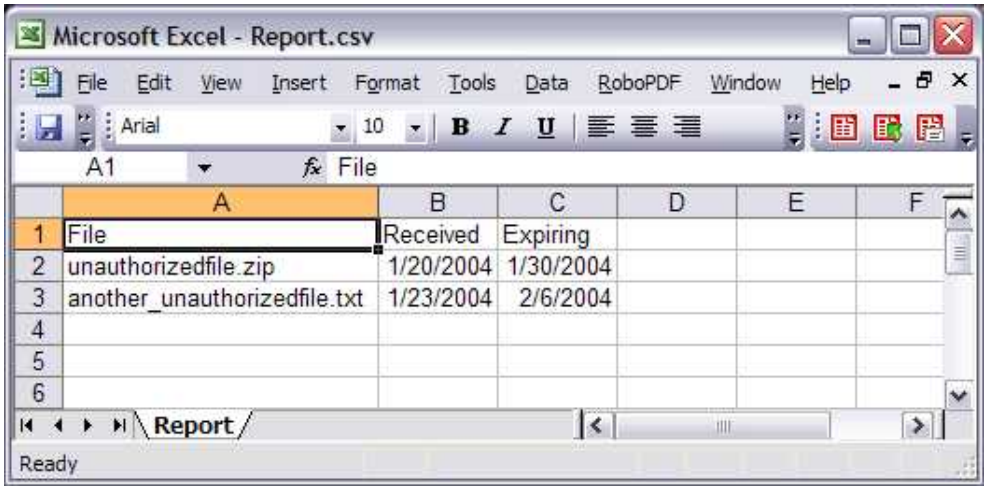
Sample Email



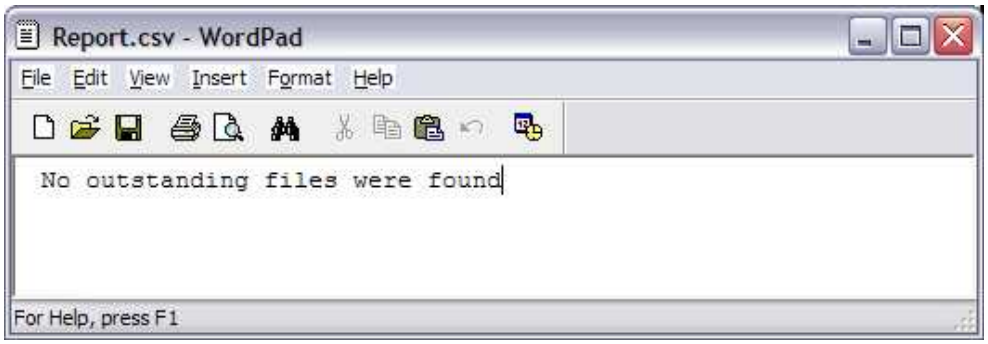
Sample Comma Delimited File



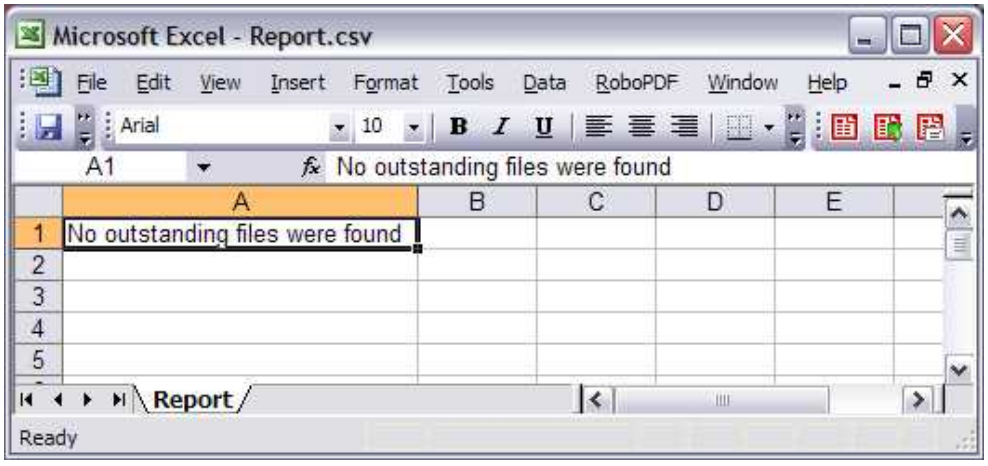
Sample Comma Delimited File as Viewed in Excel



Sample Comma Delimited File (No Files Processed)



Sample Comma Delimited File as Viewed in Excel (No Files Processed)



4. Transaction Standards

4.1 General Information

HIPAA Requirements

HIPAA standards are specified in Implementation Guides for each transaction set and in authorized Addenda. The second draft Addenda Documents for the three types of 837 Transactions have been published in final form in February 2003. In this Companion Document, AHCCCS uses 837 Transactions as modified by final Addenda. For X12 Transactions, an overview of requirements specific to each transaction can be found in each Implementation Guide. Implementation Guides contain information related to:

- The format and content of interchanges and functional groups of transactions
- Code sets and values authorized for use in the transaction

For encounters, this Companion Document, in combination with the Implementation Guide, tells how to prepare data in HIPAA standard formats for submission to AHCCCS.

Size of Transmissions/ Batches

Transmission sizes are limited based on the number of segments/records recommended by HIPAA standards. There is no AHCCCS limit on file size for electronic encounter submission. HIPAA recommendations for the maximum file size of each transaction set are specified in the Implementation Guide and its authorized Addenda.

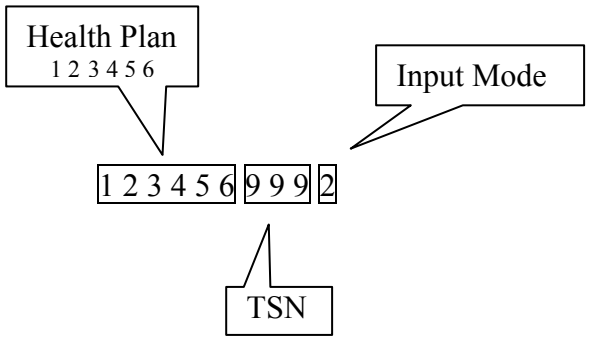
For the 837 Transaction, the Implementation Guide's recommendation is for a maximum of 5,000 CLM Claim Information Segments, generally equivalent to 5,000 claims or encounters. This does not mean that encounter submitters are limited to 5,000 encounters per submission. Multiple 837 Encounter Transactions of 5,000 encounters each can be submitted within a functional group and transmission.

AHCCCS will accept files with a maximum physical file size of 200 megabytes. The total maximum number of encounters allowed in one interchange will be 250,000 regardless of the number of transactions sets (ST/SE). The total maximum number of encounters allowed in one transaction set (ST/SE) is 50,000, preferably 5,000 as suggested in the Implementation Guide.

Health Plan ID(s) in the 837 Encounter

Health plan identifications in the 837 encounter must contain the Health Plan ID, Transmission Submitter Number (TSN), and Input Mode for the entire interchange. The following is the expected layout, example and where this ID appears:

Health Plan ID		9(6)
Transmission Submitter Number	9(3)	
Input Mode	9(1)	
		"2" Adjudicated Encounter
		"6" Denied Encounter



Required as the Submitter
1000A Submitter Name
NM109 – Submitter Primary Identification Number

There will be one 2320 Other Subscriber Information Loop that represents the Health Plan
2330B Other Payer Name
NM109 – Other Payer Primary Identifier

There will be one 2430 Line Adjudication Loop that details the Health Plan Payment/Denial
2430 Line Adjudication
SVD01 – Payer Identifier

4.2 Edits for Encounter Transactions

Overview of the Syntactical Edit Process

Edits performed by the AHCCCS translator on 837 Encounter Transactions ensure that incoming transactions comply with the standards documented in each transaction's HIPAA Implementation Guide. Only 837 Transactions of encounters that have passed translator edits can have their encounters translated and adjudicated. The translator's edits are prior to and in addition to edits performed by PMMIS. AHCCCS processes and procedures for resolution of encounters pended by PMMIS remain unchanged.

AHCCCS uses the 997 Functional Acknowledgement Transaction to acknowledge each functional group of 837 Transactions that has passed translator edits and the 824 Implementation Guide Reporting Transaction to inform 837 submitters of "syntactical" problems. Syntactical errors differ from "semantic" errors in that they involve data structures rather than meanings of data elements. In general, the AHCCCS translator handles syntactical edits and PMMIS handles semantic edits.

The 997 and 824 are ASC X12 Transactions that are not explicitly required by HIPAA rules but are available to perform acknowledgement and error notification functions electronically. The 997 is documented in Appendix B of every HIPAA Implementation Guide. The 824 has its own ASC X12 (but non-HIPAA) Implementation Guide. A final version of it is available from the Washington Publishing Company. Call Washington Publishing's Order Desk at (301) 949-9740 for information on payment procedures.

Four types of edits (in addition to preliminary edits that involve only ISA/IEA outer envelopes) are handled by the AHCCCS translator and reported on 824 Transactions. They are:

1. Integrity Edits
   This kind of edit validates the basic syntactical integrity of the incoming EDI file.

2. Implementation Guide-Requirements Edits
   This kind of edit involves requirements imposed by the transaction's HIPAA Implementation Guide, including validation of data element values specified in the Guide.

3. Balancing Edits
   Balancing verification requires that summary-level data be numerically consistent with corresponding detail level data, as defined in the transaction's Implementation Guide.

4. Inter-Segment Situation Edits
   Edits to validate inter-segment situations specified in the Implementation Guide (e.g., for accident claims, an Accident Date must be present).

In addition to carrying error codes, the 824 Transaction shows the relative location of erroneous data structures with error position designators. For a large transaction, each of the generic edit code values can be repeated in many code to element combinations.

In addition to carrying Data Element Syntax Error Codes, the 824 shows the relative location of erroneous elements with error position designators. For a large transaction, each of the ten values listed above could be repeated in many code to element combinations.

Standards for all of the above edits are based on HIPAA Implementation Guides and are not specific to AHCCCS. Other X12 trading partners can be expected to use the same conventions.

4.3 Data Interchange Conventions

Overview of Data Interchange

When receiving 837 Encounter Transactions from health plans, AHCCCS follows standards developed by the Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI). These standards involve Interchange (ISA/IEA) and Functional Group (GS/GE) Segments or "outer envelopes". All 837 Transactions are enclosed in transmission level ISA/IEA envelopes and, within transmissions, functional group level GS/GE envelopes. The segments and data elements used in outer envelopes are documented in Appendix B1 of Implementation Guides.

Transaction Specifications that say how individual data elements are populated by AHCCCS on ISA/IEA and GS/GE envelopes appear in the table beginning on the next page. This document assumes that security considerations involving user identifiers, passwords, and encryption procedures are handled by the AHCCCS FTP Server and not through the ISA Segment.

The ISA/IEA Interchange Envelope, unlike most ASC X12 data structures, has fixed fields of a fixed length. Blank fields cannot be left out.

Sender and Receiver Identification Numbers in ISA and GS Segments are assigned in Trading Partner Tables maintained by AHCCCS.

Outer Envelope Specifications Table

Definitions of table columns follow:

Loop ID
The Implementation Guide's identifier for a data loop within a transaction. Always "NA" in this situation because segments in outer envelopes have segments and elements but not loops.

Segment ID
The Implementation Guide's identifier for a data segment.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition/Length
How the data element is defined in the Implementation Guide. For ISA and IEA Segments only, fields are of fixed lengths and are present whether or not they are populated. For this reason, field lengths are provided in this column after element definitions.

Valid Values
The data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
ISA INTERCHANGE HEADER						
NA	ISA	ISA01	AUTHORIZATION INFORMATION QUALIFIER	Code to identify the type of information in the Authorization Information Element/2 Bytes	00	No Authorization Information Present
NA	ISA	ISA02	AUTHORIZATION INFORMATION	Information used for additional identification or authorization of the interchange sender or the data in the interchange; the type of information is set by the Authorization Information Qualifier/10 bytes		Leave field blank – not used by AHCCCS.
NA	ISA	ISA03	SECURITY INFORMATION QUALIFIER	Code to identify the type of information in the Security Information/2 bytes	00	No Security Information present
NA	ISA	ISA04	SECURITY INFORMATION	This field is used for identifying the security information about the interchange sender and the data in the interchange; the type of information is set by the Security Information Qualifier/10 bytes		Leave field blank – not used by AHCCCS.
NA	ISA	ISA05	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 bytes	ZZ	Mutually Defined
NA	ISA	ISA06	INTERCHANGE SENDER ID	Identification code published by the sender for other parties to use as the receiver ID to route data to them; the sender always codes this value in the sender ID element/15 bytes		The Interchange Sender ID consists of a 3-byte acronym assigned by AHCCCS followed by the submitter's Tax ID.
NA	ISA	ISA07	INTERCHANGE ID QUALIFIER	Qualifier to designate the system/method of code structure used to designate the sender or receiver ID element being qualified/2 bytes	ZZ	Mutually Defined
NA	ISA	ISA08	INTERCHANGE RECEIVER ID	Identification code published by the receiver of the data; When sending, it is used by the sender as their sending ID, thus other parties sending to them will use this as a receiving ID to route data to them/15 bytes		"AHCCCS" followed by the nine-digit AHCCCS Federal Tax ID number ("AHCCCS866004791")
NA	ISA	ISA09	INTERCHANGE DATE	Date of the interchange/6 bytes		The Interchange Date in YYMMDD format
NA	ISA	ISA10	INTERCHANGE TIME	Time of the interchange/4 bytes		The Interchange Time in HHMM format
NA	ISA	ISA11	INTERCHANGE CONTROL STANDARDS IDENTIFIER	Code to identify the agency responsible for the control standard used by the message that is enclosed by the interchange header and trailer/1 character	U	U.S. EDI Community of ASC X12, TDCC, and UCS

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
NA	ISA	ISA12	INTERCHANGE CONTROL VERSION NUMBER	This version number covers the interchange control segments/5 bytes	00401	Draft Standards for Trial Use Approved for Publication by ASC X12 Procedure Review Board through October 1997
NA	ISA	ISA13	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 bytes		ISA13 must be unique within all transmissions (i.e., files) submitted to AHCCCS by the same entity. AHCCCS tracks this number to guard against duplicate file submissions. ISA13 must also be identical to the control number in Interchange Trailer element IEA02.
NA	ISA	ISA14	ACKNOWLEDGE-MENT REQUESTED	Code sent by the sender to request an Interchange Acknowledgement (TA1)/1 character	0	Interchange Acknowledgement Requested AHCCCS returns a TA1 Application Acknowledgement to the encounter submitter if there are errors in the outer envelope.
NA	ISA	ISA15	USAGE INDICATOR	Code to indicate whether data enclosed is test, production or information/1 character	P or T	Production Data or Test Data
NA	ISA	ISA16	COMPONENT ELEMENT SEPARATOR	The delimiter value used to separate components of composite data elements/1 character	|	Trading partners can use any conventions they wish to establish separators or delimiters within transactions. The AHCCCS translator interprets separator values from their use in ISA Segments and in ISA16. Trading partners are free to adopt the values used by AHCCCS on outgoing transactions (see below). A “pipe” (the symbol above the backslash on most keyboards) is the value used by AHCCCS for component separation. Segment and element level delimiters do not require separate ISA elements to identify them. Delimiter values, by definition, cannot be used as data, even within free-form

ISA/IEA INTERCHANGE CONTROL ENVELOPE SPECIFICATIONS						
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Values**	**Definition/Format**
						messages. The following separator or delimiter values are used by AHCCCS on outgoing transactions and are available to encounter submitters: Segment Delimiter - "~' (tilde – hexadecimal value X"7E") Element Delimiter - "{" (left rounded bracket – hexadecimal value X"7B") Composite Component Delimiter (ISA16) - "|" (pipe – hexadecimal value X"7C") These values are used because they are not likely to occur within transaction data.
IEA INTERCHANGE TRAILER						
NA	IEA	IEA01	NUMBER OF INCLUDED FUNCTIONAL GROUPS	A count of the number of functional groups included in an interchange/5 bytes		The number of functional groups of transactions in the interchange
NA	IEA	IEA02	INTERCHANGE CONTROL NUMBER	A control number assigned by the interchange sender/9 bytes		A control number identical to the header-level Interchange Control Number in ISA13.

GS/GE FUNCTIONAL GROUP ENVELOPE SPECIFICATIONS							
Loop ID	**Seg ID**	**Element ID**	**Element Name**	**Element Definition/Length**	**Valid Value**	**Definition/Format**	**Source**
GS FUNCTIONAL GROUP HEADER							
NA	GS	GS01	FUNCTIONAL IDENTIFIER CODE	Code identifying a group of application related transaction sets	HC	Health Care Claim (837)	HIPAA Code Set
NA	GS	GS02	APPLICATION SENDER'S CODE	Code identifying party sending transmission; codes agreed to by trading partners		The Application Sender's Code consists of a 3-byte acronym assigned by AHCCCS followed by the AHCCCS Health Plan ID.	Transmission sender
NA	GS	GS03	APPLICATION RECEIVER'S CODE	Codes identifying party receiving transmission. Codes agreed to by trading partners		"AHCCCS" followed by the nine-digit AHCCCS Federal Tax ID number ("AHCCCS866004791")	Transmission sender
NA	GS	GS04	DATE	Date expressed as CCYYMMDD		The functional group creation date.	Transmission sender
NA	GS	GS05	TIME	Time on a 24-hour clock in HHMM format.		The functional group creation time.	Transmission sender
NA	GS	GS06	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		A control number for the functional group of transactions.	Transaction sender
NA	GS	GS07	RESPONSIBLE AGENCY CODE	Code used in conjunction with Element GS08 to identify the issuer of the standard	X	Accredited Standards Committee X12	HIPAA Code Set
NA	GS	GS08	VERSION/ RELEASE/ INDUSTRY IDENTIFIER CODE	Code that identifies the version of the transaction(s) in the functional group		837D = 004010X097A1 837I = 004010X096A1 837P = 004010X098A1 AHCCCS uses Addenda versions of all HIPAA Transactions. This Version Number incorporates the final Addenda.	HIPAA Code Set
GE FUNCTIONAL GROUP TRAILER							
NA	GE	GE01	NUMBER OF TRANSACTION SETS INCLUDED	The number of transactions in the functional group ended by this trailer segment			Transmission sender
NA	GE	GE02	GROUP CONTROL NUMBER	Assigned number originated and maintained by the sender		This number must match the control number in GS06.	Transmission sender

4.4 Acknowledgement Procedures

Overview of Electronic Acknowledgment Processes

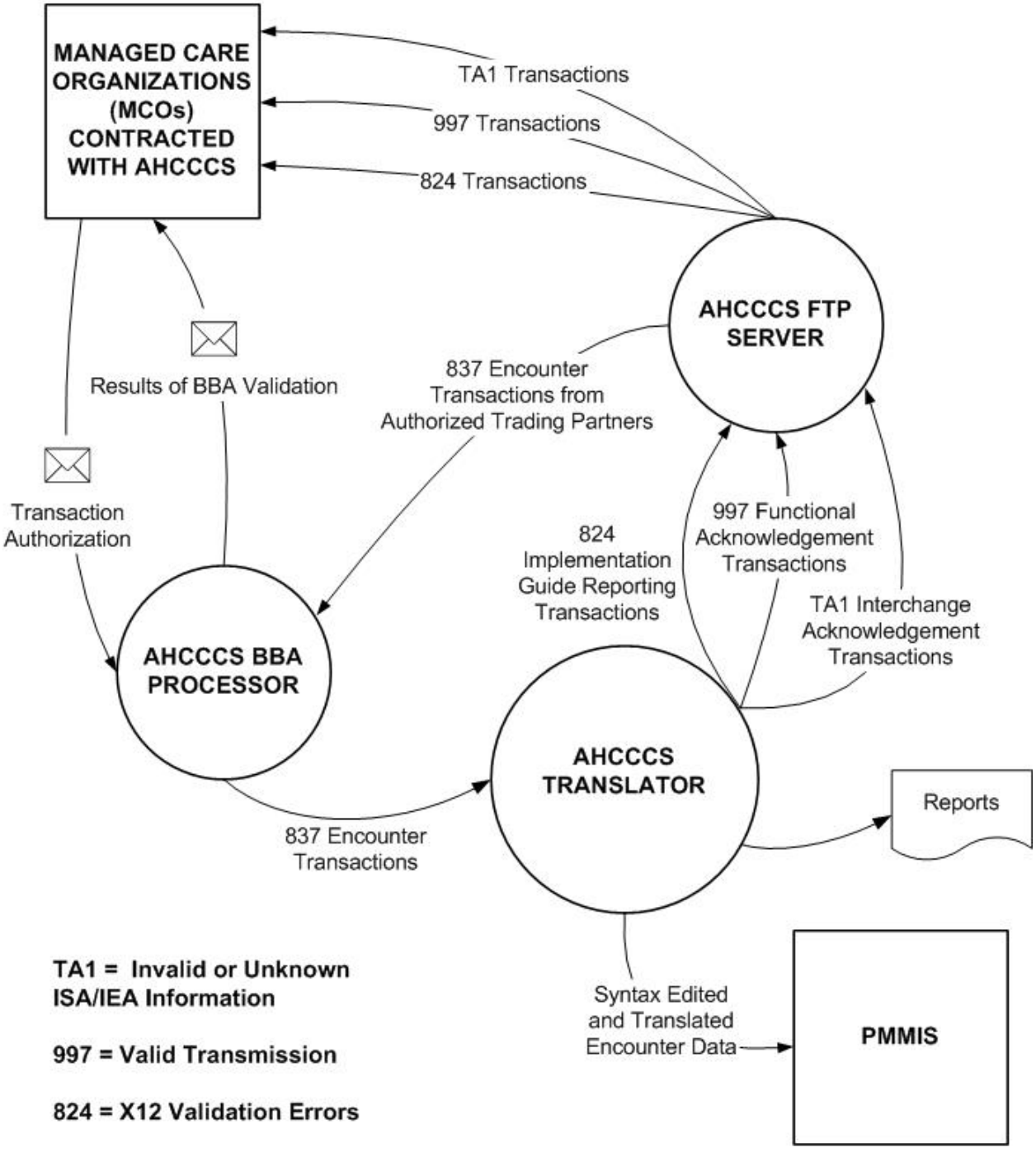
The diagram on the next page, AHCCCS Interchange Flow for 837 Encounter Transactions, shows how the AHCCCS translator accepts, acknowledges, and reports problems on 837 Encounters from health plans. The AHCCCS electronic acknowledgement and error reporting process affects all types of 837 Encounter Transactions (Professional, Dental, and Institutional).

As shown at the top of the diagram, encounter submitters transmit 837 Transactions to the AHCCCS File Transfer Protocol (FTP) Server. The AHCCCS translator uploads authorized electronic transmissions from the Server into the translator. At this point, the translator checks data in the ISA/IEA outer envelope of the interchange (i.e., transmission or file). It returns a TA1 Application Acknowledgement Segment to the claim submitter if there are errors in the outer envelope. When this happens, data within the transmission is not processed further.

For transmissions that are valid on the interchange level, the translator edits transactions and uses 824 Implementation Guide Reporting Transactions to report problems. The syntactical edits reported on the 824 are required to ensure that complex electronic transactions are assembled and formatted correctly. For syntactically valid functional groups of transactions, 997s are returned as electronic acknowledgements.

Finally comes the actual translation of syntactically valid data from the 837 Transaction to PMMIS. Elements from 837 Transactions are moved to PMMIS Tables for claim adjudication and reporting. Values of HIPAA code sets are converted to AHCCCS code set values and/or reformatted for use in claim adjudication and reporting.

AHCCCS Interchange Flow for 837 Claim Transactions



4.5 Rejected Transmissions and Transactions

Overview of Rejection Process

Upon receiving an electronic transmission from an encounter submitter, the AHCCCS translator's first action is to check for presence and validity of data in the transaction's outer envelope of ISA and IEA Interchange Header and Trailer Segments. If ISA/IEA data is valid, processing continues. If the segments have errors, the entire file is rejected with a TA1 Interchange Acknowledgement Transaction with a descriptive error code. The submitter must correct the problem in the outer envelope and resubmit all transactions in the transmission.

Next come the translator's syntactical edits on the transaction or transactions within the outer envelope. When an incoming functional group of one or more 837 Transactions has passed the translator's syntactical edits, AHCCCS returns a 997 Functional Acknowledgement Transaction with a Functional Group Acknowledge Code (AK901) of "A" (Accepted) to signify acceptance. For functional groups with errors, one or more 824 Implementation Guide Reporting Transactions reject each 837 Transaction (ST through SE) within the functional group with an Application Acknowledgement Code (OTI01) beginning with "R" (Reject).

Any error detected by the translator results in rejection of the transaction (ST/SE). For rejected transactions, AHCCCS makes use of standard 824 error location designators to identify each erroneous data structure. The translator reports all transaction errors that it can identify. It does not stop editing when it detects a problem.

A transmission will receive only on acknowledgement, dependent upon the situation. For example, a transmission contains one Functional Group (GS/GE) with multiple transactions (ST/SE). One transaction contains encounters in error. The submitter will receive one 824 transaction detailing the errors. If the transmission contained no errors, the 997 would be returned.

5. Transaction Specifications

5.1 Transaction Specifications

Purpose

Transaction specifications are designed, in combination with the HIPAA Implementation Guides, to identify data to be transmitted between particular trading partners and to specify its type and format. This information supplements the requirements in HIPAA Transaction Implementation Guides. Data structures that are fully covered by the HIPAA Implementation Guide are not mentioned in this section.

Only transaction data with submission requirements specific to AHCCCS encounters is included. For example, the 2320 Other Subscriber Information Loop and the loops within it are used on AHCCCS X12 encounters to report, on one iteration, health plan adjudication information and, on additional iterations, adjudication information from other carriers that also contributed to payment. This AHCCCS usage is not discussed explicitly in the 837 Professional Implementation Guide but is covered in this Companion Document.

Relationship to HIPAA Implementation Guides

Transaction specifications are intended to supplement the data in the Implementation Guides for each transaction set with specific information pertaining to the trading partners using the transaction set.

The information in the Transaction Specifications is not intended to:

- Modify the definition, data condition, or use of any data element or segment in the standard Implementation Guides.
- Add any additional data elements or segments to the defined data set.
- Utilize any code or data values that are not valid in the standard Implementation Guides.
- Change the meaning or intent of any implementation specifications in the standard Implementation Guides.

5.2 Encounter Transaction Specifications – Professional 837 Encounters

Overview

837 Encounter Transactions from AHCCCS health plans contain data to enable AHCCCS to process and report on services to health plan members. The purposes of these Transaction Specifications are to identify critical data elements and data element values that AHCCCS needs in Encounter Transactions and to let health plans know how to populate encounter data for AHCCCS.

The specifications described in this section apply only to 837 Professional Encounter Transactions that health plans send to AHCCCS, not to claims that fee for service providers submit to AHCCCS. Only data elements that are used by AHCCCS in ways that require explanations that go beyond information in standard Implementation Guides are included.

General Transaction Specifications

Professional 837 Encounter Transaction Specifications that are not specific to an individual data element are discussed below.

- All Professional 837 Encounter Loops, Segments, and Elements are of variable length. Segments within loops and elements within segments occur only when data is present. There are no blank or null fields.

- For 837 Encounter Transactions, AHCCCS is considered the "destination payer". The destination payer is the payer that receives and adjudicates a claim or encounter even when (as with AHCCCS) there is no direct payment as a result of adjudication.

- On encounters submitted to AHCCCS, 837 loops, segments, and data elements that involve coordination of benefits with other payers are used in two ways:
  - To show payments made to medical providers by the submitting health plan.
  - To show payments made by third party carriers, including Medicare and commercial health insurance companies.

  One iteration of the 2320 Other Subscriber Information Loop (and all data subservient to the 2320 Loop) on Professional 837 Transactions is always for the submitting health plan and is always required. Up to nine additional situational iterations of the 2320 Loop are available for additional other payers.

Transaction Specifications Table

The Professional 837 Encounter Transaction Specifications for individual data elements are shown in the table starting on the next page. Definitions of table columns follow.

AHCCCS Usage
Identifies how elements are used within the PMMIS encounter adjudication process.

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the Industry Name differs from the Data Element Dictionary name, the more descriptive Industry Name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
Data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

Professional Services New Day Encounter File Record Layout Example

Notes:

- Some data elements can be reported at the encounter header or service line level. Data reported at the header applies to the entire claim, unless overridden by the reported line level information. Data reported at the line level should not be the same as reported at the header. If the data is the same, it should be reported at either the line or the header, but not both. An example of an element that can be reported at either the claim header or the service line is the Place of Service Code.
- If the Billing and Pay-To provider data are identical, then use the Billing provider data only.
- Data elements in the example are for basic encounter data reporting needs. Additional data must be reported when required.
- Situational data must be reported when conditions identified in the implementation guide. Some examples of the identified conditions include: special program code, auto accident, oxygen therapy, medical supplies, etc.
- Reporting of other situational data elements may aide in bypassing encounter edits. E.g., contractor's prior approval or certification number would bypass service limits, timely filing or medical review edits.
- Medicare and other payer coverage information, e.g., paid, allowed, deductible, coinsurance, etc., must be reported in appropriate 2430 COB loops.
- Additional claim level or line level adjudication information, e.g., COB, bundling and/or unbundling, must be supplied to adequately support accurate encounter processing.

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required	N/A	ST	ST01	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set	837	Health Care Claim
Required	N/A	ST	ST02	Transaction Set Control Number	The unique identification number within a transaction set functional group		An identification number for the 837 Professional transaction that is unique within the transaction's functional group. As implemented by AHCCCS, 837 Professional Transactions must occur within functional groups defined by ASC X12 GS/GE envelopes. The value in ST02 must be repeated in the SE02 Element at the end of the transaction.
Required	N/A	BHT	BHT01	Hierarchical Structure Code	Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	0019	Information Source, Subscriber, Dependent The "0019" values is required in the 837 Professional Implementation Guide even when Dependent Segments are not present.
Required	N/A	BHT	BHT02	Transaction Set Purpose Code	Code identifying purpose of transaction set	00 18	Original Reissue BHT02 is intended to convey the electronic transmission status of the 837 batch contained in this ST-SE envelope. The terms "original" and "reissue" refer to the electronic transmission status of the 837 batch, not the billing status. ORIGINAL: Original transmissions are claims/encounters which have never been sent to the receiver. Generally nearly all transmissions to a payer entity (as the ultimate destination of the transaction) are original. REISSUE: In the case where a transmission was disrupted the receiver can request that the batch be sent again. Use "Reissue" when resending transmission batches that have been previously sent.
Required	N/A	BHT	BHT03	Originator Application Transaction Number	Trace or control number assigned by the originator of the transaction		A Transaction Identification Number, or inventory file number, assigned by the 837 Professional requester. This number operates as a batch control number. It may or may not be identical to the number carried in ST02.
Required	N/A	BHT	BHT04	Transaction Set Creation Date	Identifies the date the submitter created the transaction		The date on which the 837 Professional Transaction is created in CCYYMMDD format.
Required	N/A	BHT	BHT05	Transaction Set Creation Time	Time file is created for transmission		The time at which the transaction is created in HHMMSS format

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required	N/A	BHT	BHT06	Claim or Encounter Identifier	Code specifying the type of transaction	RP	Reporting RP is used when the entire ST-SE envelope contains encounters.
Required	1000A	NM1	NM109	Submitter Identifier	Code or number identifying the entity submitting the claim		Submitting health plans are identified by a six-character AHCCCS Health Plan ID, a three-character Transmission Submitter Number (TSN), and a one-character Input Mode ("2" [Adjudicated Encounter] or "6" [Denied Encounter]).
Required	1000B	NM1	NM103	Receiver Name	Name of organization receiving the transaction	AHCCCS	The transaction receiver
Required	1000B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	46	Electronic Transmitter Identification Number (ETIN)
Required	1000B	NM1	NM109	Receiver Primary Identifier	Primary identification number for the receiver of the transaction	866004791	The AHCCCS Federal Tax ID
Required	2010AA	NM1	NM109	Billing Provider Identifier	Primary identification for the billing provider		The Billing Entity's EIN, SSN or NPI
Required	2010AA	REF	REF02	Billing Provider Additional Identifier	Secondary identification for the billing provider		The Billing Entity's 6-digit AHCCCS Provider ID and 2-digit Location Code
Required if not billing provider otherwise not used	2010AB	NM1	NM109	Pay-to Provider Identifier	Primary identification for the pay-to provider		The Pay-To Entity's EIN, SSN or NPI
Required if not billing provider otherwise not used	2010AB	REF	REF02	Pay-to Provider Additional Identifier	Secondary identification for the pay-to provider		The Pay-To Entity's 6-digit AHCCCS Provider ID and 2-digit Location Code
Required	2000B	SBR	SBR09	Claim Filing Indicator Code	Code identifying type of claim	MC	Medicaid AHCCCS requests a "MC" value in this element in order to invoke translator edits that require Medicaid Provider Numbers with "1D" Qualifiers on "MC" claims or encounters.
Required	2010BA	NM1	NM109	Subscriber Primary Identifier	Primary identification number of the subscriber to the coverage		AHCCCS Recipient ID
Required	2010BB	NM1	NM103	Payer Name	Name identifying the payer organization	AHCCCS	The "destination payer" according to the Implementation Guide.
Required	2010BB	NM1	NM109	Payer Identifier	Number identifying the payer organization	866004791	The AHCCCS Federal Tax Id Number
Required	2300	CLM	CLM01	Patient Account Number	Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim		This is the Patient Account Number used by the provider that performed the service, not the number assigned by the health plan. For HIPAA, the maximum length of the field is 20 characters.

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required	2300	CLM	CLM02	Total Claim Charge Amount	The total amount of all submitted charges of service segments for the claim		The sum of all encounter line billed amounts
Required	2300	CLM	CLM05-1	Facility Type Code	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format		Place of Service is submitted at the encounter level but stored at the service line level on PMMIS Encounter Tables. Place of Service Codes submitted at the encounter level apply to all service lines unless overridden by a different Place of Service at the line level.
Required	2300	CLM	CLM05-3	Claim Frequency Code	Code specifying the frequency of the claim This is the third position of the Uniform Billing Claim Form Bill Type	1 7 8	Original Replacement (Replacement of prior encounter) Void (Void/Cancel of prior encounter)
Required when encounter submission is untimely otherwise not used	2300	CLM	CLM20	Delay Reason Code	Code indicating the reason why a request was delayed	1 2 3 4 5 6 7 8 9 10 11	Proof of Eligibility Unknown or Unavailable Litigation Authorization Delays Delay in Certifying Provider Delay in Supplying Billing Forms Delay in Delivery of Custom-made Appliances Third Party Processing Delay Delay in Eligibility Determination Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules Administration Delay in the Prior Approval Process Other This data element is required when an encounter is submitted late (past the contracted date of filing limitations). If the reason for the delay is not specified in the list, enter "11" (Other).
Required for all but fee-for-service payment arrangements	2300	CN1	CN101	Contract Type Code	Code identifying a contract type	02 03 04 05 06 09	Per Diem Variable Per Diem Flat Capitated Percent Other
Required when purchased services are reported otherwise not used	2300	AMT	AMT02	Total Purchased Service Amount	Amount of charges associated with the claim attributable to purchased services		Required if there are purchase service components to an encounter.
Required for voids or replacements	2300	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number Required for replacement and void encounters (CLM05-3 = "7" or "8").

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required for voids or replacements	2300	REF	REF02	Claim Original Reference Number	Number assigned by a processor to identify a claim		For replacement and void encounters (CLM05-3 = “7” or “8”), the AHCCCS Claim Reference Number (CRN) of the prior encounter being replaced or voided.
Situational, may be reported	2300	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	EA	Medical Record Number
Situational, may be reported	2300	REF	REF02	Medical Record Number Reference Identification	Medical record number		The Medical Record Number assigned to the AHCCCS recipient by the servicing organization
Required	2300	HI	HI01-2	Principal Diagnosis Code	Health care industry code ICD-9 Diagnosis Code		Diagnosis Codes
Required when other diagnosis codes are present on original claim from provider	2300	HI	HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2	Additional Diagnosis Code	Health care industry code ICD-9 Diagnosis Code		Diagnosis Codes Required if submitted by provider.
Required if not the billing or pay-to provider, or locum tenans; otherwise not used	2310B	NM1	NM109	Rendering Provider Identifier	Primary identification for the rendering provider		The Service Provider’s EIN, SSN or NPI
Required if not the billing or pay-to provider, or locum tenans; otherwise not used	2310B	REF	REF02	Rendering Provider Secondary Identifier	Secondary identification for the rendering provider		The Service Provider’s 6-digit AHCCCS Provider ID and 2-digit Location Code
Required	2320	SBR	SBR01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	P S T	Primary Secondary Tertiary The 2320 Other Subscriber Information Loop can occur up to ten times for up to ten payers other than AHCCCS. One iteration of the loop is always for the individual health plan that submits the encounter. Additional 2320 Loops are for payers other than the member’s health plan. They can have any responsibility sequence and may be for subscribers other than the health plan member (e.g., family members). The 2320 Loop is an “umbrella loop” that contains within it Loops 2330A through 2330E. All of these loops can be repeated as needed for each payer.

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required only if not reported at service line and if claim level charges/ units not fully paid	2320	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment		Enter the code value in the Implementation Guide that best describes the reason for any difference between the header level Charged Amount and the Paid Amount. The use of the CAS segment at the claim header is discouraged for professional encounters. The adjustments should appear at the line level (2430 Loop).
Required only if not reported at service line and if claim level charges/ units not fully paid	2320	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	Many Code Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company's Web Site (www.wpc-edi.com). Submit the code value or values that best describe the reason for the difference between the Charged Amount and the Paid Amount. These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction. The 837 Transaction is designed in the Implementation Guide to pick them up from the other payer's 835. If a health plan transmits 835 Remittance Advice Transactions to providers, data from these transactions can be the source of the Adjustment Reason Code(s) on the initial health plan iteration of the 2320 Loop. For additional other carriers, the Adjustment Reason Code(s) can be transferred (or generated by the health plan) if available. The "adjustment trio", consisting of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity, occurs up to six times within each CAS Segment.
Required only if not reported at service line and if claim level charges/ units not fully paid	2320	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		The difference between the encounter level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02.
Required only if not reported at service line and if claim level charges/ units not fully paid	2320	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		The difference between the billed and paid units of service for all service lines when the difference is the result of claim level adjudication and is associated with the Adjustment Reason Code in CAS02.
Required	2320	AMT	AMT01	COB Payer Paid Amount Qualifier	Code qualifying the COB Payer Paid Amount	D	

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required (zero is allowed for capitated services)	2320	AMT	AMT02	COB Payer Paid Amount	The amount paid by the payer on this claim		The encounter level Amount Paid by the payer of this 2320 Loop. On health plan 2320 Loops, this is the encounter level Health Plan Paid Amount.
Required	2320	AMT	AMT01	COB Allowed Amount Qualifier	Code qualifying the COB Allowed Amount	B6	The encounter level Allowed Amount for the payer of the 2320 Loop.
Required (zero is not permitted)	2320	AMT	AMT02	COB Allowed Amount	The maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment		The encounter level Allowed Amount for the payer of this 2320 Loop. For health plan 2320 Loops, the Allowed Amount is always greater than zero.
Required	2330A	NM1	NM109	Other Insured Identifier	An identification number, assigned by the third party payer, to identify the additional insured individual		In the health plan 2320 Loop, the identifies the health plan's AHCCCS ID, TSN and Input Mode. In subsequent 2320 Loops, the Subscriber ID assigned by the other payer.
Required	2330B	NM1	NM109	Other Payer Primary Identifier	An identification number for the other payer		In the health plan 2320 Loop, the health plan's AHCCCS ID, TSN, and Input Mode. In additional 2320 Loops, any identification number assigned by the health plan to the other payer in this required element. AHCCCS will not perform validity edits on this identifier for payers other than contracted health plans.
Required	2330B	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	F8	Original Reference Number
Required	2330B	REF	REF02	Other Payer Secondary Identifier	Additional identifier for the other payer organization		The health plan or other payer's Claim Number for the claim that generated this encounter.
Required for voids or replacements	2330B	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	T4	Signal Code
Required for voids or replacements	2330B	REF	REF02	Other Payer Claim Adjustment Indicator	Indication that the claim is an adjustment of a previously adjudicated claim		Health Plan's Indication of Claim Re-adjudication
Required	2400	LX	LX01	Service Line Assigned Number	Service line number that functions as a line counter		Line Counter

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required	2400	SV1	SV101-1	Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID	HC	Health Care Financing Administration Common Procedural Coding System (HCPCS) Codes
Required	2400	SV1	SV101-2	Procedure Code	Code identifying the professional product or service		The HCPCS Code valid on the date of service
Required if modifiers are reported	2400	SV1	SV101-3	Procedure Modifier	This identifies special circumstances related to the performance of the service		The first Procedure Code Modifier submitted by the provider to the health plan.
Required if modifiers are reported	2400	SV1	SV101-4	Procedure Modifier	This identifies special circumstances related to the performance of the service		The second Procedure Code Modifier submitted by the provider to the health plan.
Required if modifiers are reported	2400	SV1	SV101-5	Procedure Modifier	This identifies special circumstances related to the performance of the service		The third Procedure Code Modifier submitted by the provider to the health plan.
Required if modifiers are reported	2400	SV1	SV101-6	Procedure Modifier	This identifies special circumstances related to the performance of the service		The fourth Procedure Code Modifier submitted by the provider to the health plan.
Required	2400	SV1	SV102	Line Item Charge Amount	Submitted monetary charge amount		Provider's Service Line Charged Amount
Required	2400	SV1	SV104	Service Unit Count	Numeric value of quantity		Provider's Service Line Units
Required if different from claim level	2400	SV1	SV105	Facility Code Value	Code identifying the type of facility where services were performed		Place of Service Code Place of Service at the line level will override the Place of Service at the encounter level.
Required	2400	SV1	SV107-1	Diagnosis Code Pointer	A pointer to the claim diagnosis code in order of importance to the service		Diagnosis Code Pointer
Required when multiple diagnosis codes are reported	2400	SV1	SV107-2, SV107-3, SV107-4	Diagnosis Code Pointer	A pointer to the claim diagnosis code in order of importance to the service		Diagnosis Code Pointer Required if submitted on original claim from provider.

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required if result of referral	2400	SV1	SV111	EPSDT Indicator	An indicator of whether or not Early and Periodic Screening for Diagnosis and Treatment of children services are involved with this detail line	Y	Yes, the service is the result of an EPSDT referral Required if a Medicaid service is the result of a screening referral. This service referenced by this service line element differs from the data on the referral itself in the encounter level EPSDT CRC Segment. This new segment has been introduced by the 837 Professional Addenda. SV111 indicates a service that results from an EPSDT referral, not the original EPSDT evaluation.
Required	2400	DTP	DTP03	Service Date Date Time Period	Expression of date or range of dates when service occurred		Begin and End Dates of Service
Required if different from claim level	2400	CN1	CN101	Contract Type Code	Code identifying a contract type	 02 03 04 05 06 09	Subcapitated Code Per Diem Variable Per Diem Flat Capitated Percent Other
Required	2400	AMT	AMT01	Amount Qualifier	Code to qualify amount	AAE	Approved Amount
Required if different from claim level	2400	AMT	AMT02	Approved Amount	Monetary amount		The payment amount approved by the health plan
Situationally Required	2400	PS1	PS101	Purchased Service Provider Identifier	The provider number of the entity from which service was purchased		The PS101 element is for the provider identification number, the ID of the provider “from which service was purchased”, The PS1 Segment is required on service lines that involve purchased services/tests if the ID and/or Amount are different from the information given at the claim level (Loop 2310C). For purchased service lines, including transplants, enter the AHCCCS Provider ID and Location Code.
Required if not reported at the Claim Level	2430	SVD	SVD01	Other Payer Primary Identifier	An identification number for the other payer		According to this Implementation Guide, the 2430 Loop is “required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it.” The number in this field needs to match NM109 in the Loop 2330B that identifies the other payer. In the Health Plan 2430 Loop, this will be the health plan’s AHCCCS ID, TSN, and Input Mode.

837 PROFESSIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required if not reported at the Claim Level	2430	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	CO CR OA PI PR	Contractual Obligations Correction and Reversals Other Adjustments Payer Initiated Reductions Patient Responsibility Required if the payer identified in loop 2330B made line level adjustments that caused the amount paid to differ from the amount originally charged. In this situation, enter the code value that best describes the reason for the different between the Charged Amount and the Paid Amount for this service line. The “Adjustment Trio” of the Adjustment Reason, Amount, and Quantity can occur up to six times per CAS Segment and CAS Segments have up to 99 iterations at the service line level. Five hundred and ninety-four Claim Adjustment Codes for the health plan and other carrier can be accommodated.
Required if not reported at the Claim Level	2430	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	Many Code Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company's Web Site (www.wpc-edi.com). Enter the code value that best describes the reason for the difference between the Service Line Charged Amount and the Paid Amount. These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction. The “adjustment trio” of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity occur up to six times within the CAS Segment.
Required if not reported at the Claim Level	2430	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		The difference between the service line level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02.
Required if not reported at the Claim Level	2430	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		The difference between the billed and paid units of service at the service line level when the difference is the result of line level adjudication and is associated with the Adjustment Reason Code in CAS02.

5.3 Encounter Transaction Specifications – Dental 837 Encounters

Overview

837 Encounter Transactions from AHCCCS health plans contain data to enable AHCCCS to process and report on services to health plan members. The purposes of these Transaction Specifications are to identify critical data elements and data element values that AHCCCS needs in Encounter Transactions and to let health plans know how to populate encounter data for AHCCCS.

The specifications in this section apply only to 837 Dental Encounter Transactions that health plans send to AHCCCS, not to claims that fee for service providers submit to AHCCCS. Only data elements that are used by AHCCCS in ways that require explanations that go beyond information in standard Implementation Guides are included.

General Transaction Specifications

Dental 837 Encounter Transaction specifications that are not specific to a particular data element are discussed below.

- All Dental 837 Encounter Loops and Segments are of variable length. Segments within loops and elements within segments occur only when data is present. There are no blank or null fields. In some situations, zero field values are acceptable.

- For 837 Encounter Transactions, AHCCCS is considered the "destination payer". The destination payer is the payer that receives and adjudicates a claim or encounter even when (as with AHCCCS) there is no direct payment as a result of adjudication.

- On encounters submitted to AHCCCS, 837 loops, segments, and data elements that involve coordination of benefits with other payers are used in two ways:
  - To show payments made to providers by the submitting health plan.
  - To show payments made by third party carriers, including Medicare and commercial health insurance companies.

  The health plan iteration of the 2320 Other Subscriber Information Loop (and all data subservient to the 2320 Loop) on Dental 837 Transactions is always for the sending health plan. A health plan loop is required. Up to nine situational iterations of the 2320 Loop are available for additional other payers.

- Although the Dental 837 Transaction can be used to pre-approve dental

services, AHCCCS does not use it in this manner and does not expect pre-approval data on dental encounters.

Transaction Specifications Table

The Dental 837 Encounter Transaction Specifications for individual data elements are shown in the table starting on the next page. Definitions of table columns follow.

AHCCCS Usage
Identifies how elements are used within the PMMIS encounter adjudication process.

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element name as shown in the Implementation Guide. When the industry name differs from the Data Element Dictionary name, the more descriptive industry name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
Data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

Dental Services New Day Encounter File Record Layout Example

Notes:

- Some data elements can be reported at the encounter header or service line level. Data reported at the header applies to the entire claim, unless overridden by the reported line level information. Data reported at the line level should not be the same as reported at the header. If the data is the same, it should be reported at either the line or the header, but not both. An example of an element that can be reported at either the claim header or the service line is the Place of Service Code.
- If the Billing and Pay-To provider data are identical, then please use the Billing provider data only.
- Data elements in the example are for basic encounter data reporting needs. Additional data must be reported when required.
- Situational data must be reported when conditions identified in the implementation guide. Some examples of the identified conditions include: special program code, auto accident, oxygen therapy, medical supplies, etc.
- Reporting of other situational data elements may aide in bypassing encounter edits. E.g., contractor's prior approval or certification number would bypass service limits, timely filing or medical review edits.
- Medicare and other payer coverage information, e.g., paid, allowed, deductible, coinsurance, etc., must be reported in appropriate 2430 COB loops.
- Additional claim level or line level adjudication information, e.g., COB, bundling and/or unbundling, must be supplied to adequately support accurate encounter processing.

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required	N/A	ST	ST01	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set	837	Health Care Claim
Required	N/A	ST	ST02	Transaction Set Control Number	The unique identification number within a transaction set functional group		An identification number for the 837 Dental transaction that is unique within the transaction's functional group. As implemented by AHCCCS, 837 Dental Transactions must occur within functional groups defined by ASC X12 GS/GE envelopes. The value in ST02 must be repeated in the SE02 Element at the end of the transaction.
Required	N/A	BHT	BHT01	Hierarchical Structure Code	Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	0019	Information Source, Subscriber, Dependent The "0019" values is required in the 837 Dental Implementation Guide even when Dependent Segments are not present.
Required	N/A	BHT	BHT02	Transaction Set Purpose Code	Code identifying purpose of transaction set	00 18	Original Reissue BHT02 is intended to convey the electronic transmission status of the 837 batch contained in this ST-SE envelope. The terms "original" and "reissue" refer to the electronic transmission status of the 837 batch, not the billing status. ORIGINAL: Original transmissions are claims/encounters which have never been sent to the receiver. Generally nearly all transmissions to a payer entity (as the ultimate destination of the transaction) are original. REISSUE: In the case where a transmission was disrupted the receiver can request that the batch be sent again. Use "Reissue" when resending transmission batches that have been previously sent.
Required	N/A	BHT	BHT03	Originator Application Transaction Number	Trace or control number assigned by the originator of the transaction		A Transaction Identification Number, or inventory file number, assigned by the 837 Dental requester. This number operates as a batch control number. It may or may not be identical to the number carried in ST02.
Required	N/A	BHT	BHT04	Transaction Set Creation Date	Identifies the date the submitter created the transaction		The date on which the 837 Dental Transaction is created in CCYYMMDD format.
Required	N/A	BHT	BHT05	Transaction Set Creation Time	Time file is created for transmission		The time at which the transaction is created in HHMMSS format

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required	N/A	BHT	BHT06	Claim or Encounter Identifier	Code specifying the type of transaction	RP	Reporting RP is used when the entire ST-SE envelope contains encounters.
Required	1000A	NM1	NM109	Submitter Identifier	Code or number identifying the entity submitting the claim		Submitting health plans are identified by a six-character AHCCCS Health Plan ID, a three-character Transmission Submitter Number (TSN), and a one-character Input Mode ("2" [Adjudicated Encounter] or "6" [Denied Encounter]).
Required	1000B	NM1	NM103	Receiver Name	Name of organization receiving the transaction	AHCCCS	The transaction receiver
Required	1000B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	46	Electronic Transmitter Identification Number (ETIN)
Required	1000B	NM1	NM109	Receiver Primary Identifier	Primary identification number for the receiver of the transaction	866004791	AHCCCS Federal Tax ID
Required	2010AA	NM1	NM109	Billing Provider Identifier	Primary identification for the billing provider		The Billing Entity's EIN, SSN or NPI
Required	2010AA	REF	REF02	Billing Provider Additional Identifier	Secondary identification for the billing provider		The Billing Entity's 6-digit AHCCCS Provider ID and 2-digit Location Code
Required if not billing provider otherwise not used	2010AB	NM1	NM109	Pay-to Provider Identifier	Primary identification for the pay-to provider		The Pay-To Entity's EIN, SSN or NPI
Required if not billing provider otherwise not used	2010AB	REF	REF02	Pay-to Provider Additional Identifier	Secondary identification for the pay-to provider		The Pay-To Entity's 6-digit AHCCCS Provider ID and 2-digit Location Code
Required	2000B	SBR	SBR09	Claim Filing Indicator Code	Code identifying type of claim	MC	Medicaid AHCCCS requests a "MC" value in this element in order to invoke translator edits that require Medicaid Provider Numbers with "1D" Qualifiers on "MC" claims or encounters.
Required	2010BA	NM1	NM109	Subscriber Primary Identifier	Primary identification number of the subscriber to the coverage		AHCCCS Recipient ID
Required	2010BB	NM1	NM103	Payer Name	Name identifying the payer organization	AHCCCS	The name of the "destination payer" according to the Implementation Guide.
Required	2010BB	NM1	NM109	Payer Identifier	Number identifying the payer organization	866004791	The AHCCCS Federal Tax ID
Required	2300	CLM	CLM01	Patient Account Number	Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim		The Patient Account Number maintained by the provider that submitted the claim to the healthy plan that generated this encounter.
Required	2300	CLM	CLM02	Total Claim Charge Amount	The total amount of all submitted charges of service segments for this encounter		The sum of all encounter line billed amounts

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required	2300	CLM	CLM05-1	Facility Type Code	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format		Code values are listed in the Implementation Guide and in the Addendum for the 837 Dental Transaction. The Addendum states that "only codes contained in the document available from code source 237 are to be supported in this transaction and take precedence over any and all codes listed here." Code Source 237 is CMS. The Implementation Guide provides an address, Web Site, and contact person. Place of Service Codes submitted at the encounter level apply to all service lines unless overridden by a different Place of Service at the line level.
Required	2300	CLM	CLM05-3	Claim Submission Reason Code	Code identifying reason for claim submission	1 7 8	Original Replacement (Replacement of prior claim) Void (Void/Cancel of prior claim)
Required when encounter submission is untimely otherwise not used	2300	CLM	CLM20	Delay Reason Code	Code indicating the reason why a request was delayed	1 2 3 4 5 6 7 8 9 10 11	Proof of Eligibility Unknown or Unavailable Litigation Authorization Delays Delay in Certifying Provider Delay in Supplying Billing Forms Delay in Delivery of Custom-made Appliances Third Party Processing Delay Delay in Eligibility Determination Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules Administration Delay in the Prior Approval Process Other This data element is required when an encounter is submitted late (after the contracted date of filing limitations). If the reason for the delay is not specified in the list, enter "11" (Other).
Required	2300	DTP	DTP03	Service Date Date Time Period	Expression of date or range of dates when service occurred		Encounter Level Begin and End Dates of Service
Required when reporting missing, impacted, or tooth to be extracted	2300	DN2	DN202	Tooth Status Code	Code specifying the status of the tooth	 E I M	Tooth Status Code To be extracted Impacted Missing
Required for voids or replacements	2300	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number Required for replacement and void encounters (CLM05-3 = "7" or "8").

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required for voids or replacements	2300	REF	REF02	Claim Original Reference Number	Number assigned by a processor to identify a claim		For replacement and void encounters, the AHCCCS Claim Reference Number (CRN) of the prior encounter being replaced or voided.
Required if not the billing or pay-to provider, or locum tenans; otherwise not used	2310B	NM1	NM109	Rendering Provider Identifier	Primary identification for the rendering provider		The Service Provider's EIN, SSN or NPI
Required if not the billing or pay-to provider, or locum tenans; otherwise not used	2310B	REF	REF02	Rendering Provider Secondary Identifier	Secondary identification for the rendering provider		The Service Provider's 6-digit AHCCCS Provider ID and 2-digit Location Code
Required	2320	SBR	SBR01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	P S T	Primary Secondary Tertiary The 2320 Other Subscriber Information Loop can occur up to ten times for up to ten payers other than AHCCCS. One iteration of the loop is always for the individual health plan that submits the encounter. 2320 Loops, in addition to the health plan loop, are for payers other than the member's health plan. They can have any responsibility sequence and may be for subscribers other than the health plan member (e.g., family members). The 2320 Loop is an "umbrella loop" that contains within it Loops 2330A through 2330E. All of these loops can be repeated as needed for each payer.
Required only if not reported at service line and if claim level charges/ units not fully paid	2320	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment		Enter the code value in the Implementation Guide that best describes the reason for any difference between the Charged Amount and the Paid Amount. The use of the CAS segment at the claim header is discouraged for dental encounters. The adjustments should appear at the line level (2430 Loop).

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required only if not reported at service line and if claim level charges/ units not fully paid	2320	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	Many Code Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company's Web Site (www.wpc-edi.com). Submit the code value or values that best describes the reason for the difference between the Charged Amount and the Paid Amount. These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction. The 837 Transaction is designed to pick them up from the other payer's 835. If a health plan transmits 835 Remittance Advice Transactions to providers, data from these transactions can be the source of the Adjustment Reason Code(s) on the initial health plan iteration of the 2320 Loop. For subsequent other carriers, the Adjustment Reason Code(s) can be transferred (or generated by the health plan) if available. The "adjustment trio", consisting of Adjustment Reason Code, Adjustment Amount, and Adjustment Quantity, occurs up to six times within each CAS Segment.
Required only if not reported at service line and if claim level charges/ Units not fully paid	2320	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		The difference between the encounter level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02.
Required only if not reported at service line and if claim level charges/ units not fully paid	2320	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		The difference between the billed and paid units of service for all service lines when the difference is the result of claim level adjudication and is associated with the Adjustment Reason Code in CAS02.
Required	2320	AMT	AMT01	COB Payer Paid Amount Qualifier	Code qualifying the COB Payer Paid Amount	D	
Required (zero is allowed for capitated services)	2320	AMT	AMT02	Payer Paid Amount	The amount paid by the payer on this claim		The encounter level Amount Paid by the payer of this 2320 Loop. On health plan 2320 Loops, this is the encounter level Health Plan Paid Amount.
Required	2320	AMT	AMT01	COB Allowed Amount Qualifier	Code qualifying the COB Allowed Amount	B6	The encounter level Allowed Amount by the payer of this 2320 Loop.
Required (zero is not permitted)	2320	AMT	AMT02	Allowed Amount	The maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment		The encounter level Allowed Amount for the payer of this 2320 Loop. For the health plan 2320 Loop, the Allowed Amount is always greater than zero.

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Conditionally Required	2320	DMG	DMG02	Other Insured Birth Date	The birth date of the additional insured individual		The "other subscriber's" birth date in CCYYMMDD format. This DMG Segment is not needed in the health plan 2320 Loop. In additional other payer loops, this is the birth date of the subscriber (who may or may not be the same as the member).
Required	2330A	NM1	NM109	Other Insured Identifier	An identification number, assigned by the third party payer, to identify the additional insured individual		In the health plan 2320 Loop, the member's AHCCCS ID. In additional 2320 Loops, the Subscriber ID assigned by the other payer.
Required	2330B	NM1	NM109	Other Payer Primary Identifier	An identification number for the other payer		In the health plan 2320 Loop, the identifies the health plan's AHCCCS ID, TSN and Input Mode. In additional 2320 Loops, any identification number assigned by the health plan to the other payer in this required element. AHCCCS will not perform validity edits on this identifier.
Required	2230B	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	F8	Original Reference Number
Required	2330B	REF	REF02	Other Payer Secondary Identifier	Additional identifier for the other payer organization		The health plan or other payer's Claim Number for the claim.
Required for voids or replacements	2330B	REF	REF02	Other Payer Claim Adjustment Indicator	Indication that the claim is an adjustment of a previously adjudicated claim		Health Plan's Indication of Claim Re-Adjudication
Required	2400	LX	LX01	Service Line Assigned Number	Service line number that functions as a line counter		Line Counter
Required	2400	SV3	SV301-2	Procedure Code	Code identifying the dental product or service		Dental Procedure Code
Required if dental modifiers are reported	2400	SV3	SV301-3	Procedure Modifier	This identifies special circumstances related to the performance of the service		First Dental Procedure Modifier On dental encounters and claims, Procedure Modifiers must be ADA Dental Procedure Modifiers, not non-dental HCPCS Modifiers. At this time, ADA Modifiers are not finalized. Do not submit until they are available.
Required if dental modifiers are reported	2400	SV3	SV301-4	Procedure Modifier	This identifies special circumstances related to the performance of the service		Second Dental Procedure Modifier See SV301-3
Required if dental modifiers are reported	2400	SV3	SV301-5	Procedure Modifier	This identifies special circumstances related to the performance of the service		Third Dental Procedure Modifier See SV301-3
Required when dental modifiers are reported	2400	SV3	SV301-6	Procedure Modifier	This identifies special circumstances related to the performance of the service		Fourth Dental Procedure Modifier See SV301-3
Required	2400	SV3	SV302	Line Item Charge Amount	Submitted monetary charge amount		Provider's Service Line Charged Amount

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required	2400	SV3	SV303	Facility Code Value	Code identifying the type of facility where services were performed		Place of Service Code Place of Service at the line level will override Place of Service at the encounter header level
Required if different from claim level	2400	SV3	SV306	Procedure Count	Number of Procedures		This element is for the service units reported by the provider to the health plan. The units reported by the health plan to AHCCCS are captured in loop 2430.
Required when tooth number related to procedure	2400	TOO	TOO02	Tooth Code	Specific industry code indicating the tooth number		The Tooth Number as defined by the American Dental Association valid on the date of service
Required when tooth surface related to procedure	2400	TOO	TOO03-1, TOO03-2, TOO03-3, TOO03-4, TOO03-5	Tooth Surface Code	Code identifying the area of the tooth that was treated	B D F I L M O	Tooth Surface Code Buccal Distal Facial Incisal Lingual Mesial Occlusal
Required if different from claim level	2400	DTP	DTP03	Service Date Date Time Period	Expression of date or range of dates when service occurred		Begin and End Dates of Service
Required if different from claim level	2400	AMT	AMT01	Amount Qualifier	Code to qualify amount	AAE	Approved Amount
Required if different from claim level	2400	AMT	AMT02	Approved Amount	Monetary amount		The payment amount approved by the health plan
Required	2420B	NM1	NM109	Other Payer Referral Number	The non-destination (COB) payer's service line level referral number		The other payer's identification number. It must be the same as a payer's ID Number in a claim level 2330B Loop.
Required if not reported at the Claim Level	2430	SVD	SVD01	Other Payer Primary Identifier	An identification number for the other payer		According to this Implementation Guide, the 2430 Loop is "required if claim has been previously adjudicated by payer identified in Loop 2330B and service line has adjustments applied to it." The number in this field needs to match NM109 in the Loop 2330B that identifies the other payer. In the Health Plan 2430 Loop, this will be the health plan's AHCCCS ID, TSN, and Input Mode.

837 DENTAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required if not reported at the Claim Level	2430	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	CO CR OA PI PR	Contractual Obligations Correction and Reversals Other Adjustments Payer Initiated Reductions Patient Responsibility Required if the payer identified in loop 2330B made line level adjustments that caused the amount paid to differ from the amount originally charged. In this situation, enter the code value that best describes the reason for the different between the Charged Amount and the Paid Amount for this service line. The “Adjustment Trio” of Adjustment Reason, Amount, and Quantity can occur up to six times per CAS Segment and CAS Segments have up to 99 iterations at the service line level. Five hundred and ninety-four Claim Adjustment Codes for the health plan and other carriers can be accommodated.
Required if not reported at the Claim Level	2430	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	Many Code Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company’s Web Site (www.wpc-edi.com). Enter the code value that best describes the reason for the difference between the Service Line Charged Amount and the Paid Amount. These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction.
Required if not reported at the Claim Level	2430	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		The difference between the service line level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02.
Required if not reported at the Claim Level	2430	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for adjustment of benefits		The difference between the billed and paid units of service at the service line level when the difference is the result of line level adjudication and is associated with the Adjustment Reason Code in CAS02.

5.4 Encounter Transaction Specifications – Institutional 837 Encounters

Overview

837 Encounter Transactions from AHCCCS health plans contain data to enable AHCCCS to process and report on services to health plan members. The purposes of these Transaction Specifications are to identify critical data elements and data element values that AHCCCS needs in Encounter Transactions and to let health plans know how to populate encounter data for AHCCCS.

The specifications in this section apply only to 837 Institutional Encounter Transactions that health plans send to AHCCCS, not to claims that fee for service providers submit to AHCCCS. Only data elements that are used by AHCCCS in ways that require explanations that go beyond information in standard Implementation Guides are included.

General Transaction Specifications

Institutional 837 Encounter Transaction Specifications that are not specific to an individual data element are discussed below.

- With the exception of data elements in the Transaction Header Segment, all Institutional 837 Encounter Loops and Segments are of variable length. Segments within loops and elements within segments occur only when data is present. There are no blank or null fields. In some situations, zero field values are acceptable.
- For 837 Encounter Transactions, AHCCCS is considered the "destination payer". The destination payer is the payer that receives and adjudicates a claim or encounter even when (as with AHCCCS) there is no direct payment as a result of adjudication.
- On encounters submitted to AHCCCS, 837 loops, segments, and data elements that involve coordination of benefits with other payers are used in two ways:
  - To show payments made to medical providers by the sending health plan.
  - To show payments made by third party carriers, including Medicare and commercial health insurance companies.

  The health plan iteration of the 2320 Other Subscriber Information Loop (and all data subservient to the 2320 Loop) on Institutional 837 Transactions is always for the sending health plan. A health plan loop is required. Up to nine situational iterations of the 2320 Loop are available for additional other payers.

Transaction Specifications Table

The Institutional 837 Encounter Transaction Specifications for individual data elements are shown in the table starting on the next page. Definitions of table columns follow.

AHCCCS Usage
Identifies how elements are used within the PMMIS encounter adjudication process.

Loop ID
The Implementation Guide's identifier for a data loop within a transaction.

Segment ID
The Implementation Guide's identifier for a data segment within a loop.

Element ID
The Implementation Guide's identifier for a data element within a segment.

Element Name
A data element's name as shown in the Implementation Guide. When the Industry Name differs from the Data Element Dictionary name, the more descriptive Industry Name is used.

Element Definition
How the data element is defined in the Implementation Guide.

Valid Values
Data element values in the Implementation Guide that are used by AHCCCS.

Definition/Format
Definitions of valid values used by AHCCCS and additional information about AHCCCS data element requirements.

Institutional Services New Day Encounter File Record Layout Example

Notes:

- Some data elements can be reported at the encounter header or service line level. Data reported at the header applies to the entire claim, unless overridden by the reported line level information. Data reported at the line level should not be the same as reported at the header. If the data is the same, it should be reported at either the line or the header, but not both. An example of an element that can be reported at either the claim header or the service line is the Place of Service Code.
- If the Billing and Pay-To provider data are identical, then please use the Billing provider data only.
- Data elements in the example are for basic encounter data reporting needs. Additional data must be reported when required.
- Situational data must be reported when conditions identified in the implementation guide. Some examples of the identified conditions include: special program code, auto accident, oxygen therapy, medical supplies, etc.
- Reporting of other situational data elements may aide in bypassing encounter edits. E.g., contractor's prior approval or certification number would bypass service limits, timely filing or medical review edits.
- Medicare and other payer coverage information, e.g., paid, allowed, deductible, coinsurance, etc., must be reported in appropriate 2430 COB loops.
- Additional claim level or line level adjudication information, e.g., COB, bundling and/or unbundling, must be supplied to adequately support accurate encounter processing.

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required	N/A	ST	ST01	Transaction Set Identifier Code	Code uniquely identifying a Transaction Set	837	Health Care Claim
Required	N/A	ST	ST02	Transaction Set Control Number	The unique identification number within a transaction set functional group		An identification number for the 837 Institutional transaction that is unique within the transaction's functional group. As implemented by AHCCCS, 837 Institutional Transactions must occur within functional groups defined by ASC X12 GS/GE envelopes. The value in ST02 must be repeated in the SE02 Element at the end of the transaction.
Required	N/A	BHT	BHT01	Hierarchical Structure Code	Code indicating the hierarchical application structure of a transaction set that utilizes the HL segment to define the structure of the transaction set	0019	Information Source, Subscriber, Dependent The "0019" values is required in the 837 Institutional Implementation Guide even when Dependent Segments are not present.
Required	N/A	BHT	BHT02	Transaction Set Purpose Code	Code identifying purpose of transaction set	00 18	Original Reissue BHT02 is intended to convey the electronic transmission status of the 837 batch contained in this ST-SE envelope. The terms "original" and "reissue" refer to the electronic transmission status of the 837 batch, not the billing status. ORIGINAL: Original transmissions are claims/encounters which have never been sent to the receiver. Generally nearly all transmissions to a payer entity (as the ultimate destination of the transaction) are original. REISSUE: In the case where a transmission was disrupted the receiver can request that the batch be sent again. Use "Reissue" when resending transmission batches that have been previously sent.
Required	N/A	BHT	BHT03	Originator Application Transaction Number	Trace or control number assigned by the originator of the transaction		A Transaction Identification Number, or inventory file number, assigned by the 837 Institutional requester. This number operates as a batch control number. It may or may not be identical to the number carried in ST02.
Required	N/A	BHT	BHT04	Transaction Set Creation Date	Identifies the date the submitter created the transaction		The date on which the 837 Institutional Transaction is created in CCYYMMDD format.
Required	N/A	BHT	BHT05	Transaction Set Creation Time	Time file is created for transmission		The time at which the transaction is created in HHMMSS format

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required	N/A	BHT	BHT06	Claim or Encounter Identifier	Code specifying the type of transaction	RP	Reporting RP is used when the entire ST-SE envelope contains encounters.
Required	1000A	NM1	NM109	Submitter Identifier	Code or number identifying the entity submitting the claim		Submitting health plans are identified by a six-character AHCCCS Health Plan ID, a three-character Transmission Submitter Number (TSN), and a one-character Input Mode ("2" [Adjudicated Encounter] or "6" [Denied Encounter]).
Required	1000B	NM1	NM103	Receiver Name	Name of organization receiving the transaction	AHCCCS	The transaction receiver
Required	1000B	NM1	NM108	Information Receiver Identification Number	The identification number of the individual or organization who expects to receive information in response to a query	46	Electronic Transmitter Identification Number (ETIN)
Required	1000B	NM1	NM109	Receiver Primary Identifier	Primary identification number for the receiver of the transaction	866004791	AHCCCS Federal Tax ID
Required	2010AA	NM1	NM109	Billing Provider Identifier	Primary identification for the billing provider		The Billing Entity's EIN, SSN or NPI
Required	2010AA	REF	REF02	Billing Provider Additional Identifier	Secondary identification for the billing provider		The Billing Entity's 6-digit AHCCCS Provider ID and 2 digit Location Code
Required if not billing provider otherwise not used	2010AB	NM1	NM109	Pay-to Provider Identifier	Primary identification for the pay-to provider		The Pay-To Entity's EIN, SSN or NPI
Required if not billing provider otherwise not used	2010AB	REF	REF02	Pay-To Provider Additional Identifier	Secondary identification for the pay-to provider		The Pay-To Entity's 6-digit AHCCCS Provider ID and 2-digit Location Code
Required	2000B	SBR	SBR09	Claim Filing Indicator Code	Code identifying type of claim	MC	Medicaid AHCCCS requests a "MC" value in this element in order to invoke translator edits that require Medicaid Provider Numbers with "1D" Qualifiers on "MC" claims or encounters.
Required	2010BA	NM1	NM109	Subscriber Primary Identifier	Primary identification number of the subscriber to the coverage		AHCCCS Recipient ID
Required	2010BC	NM1	NM103	Payer Name	Name identifying the payer organization	AHCCCS	The "destination payer" according to the Implementation Guide.
Required	2010BC	NM1	NM109	Payer Identifier	Number identifying the payer organization	866004791	The AHCCCS Tax ID Number
Required	2300	CLM	CLM01	Patient Account Number	Unique identification number assigned by the provider to the claim patient to facilitate posting of payment information and identification of the billed claim		This is the Patient Account Number used by the provider that performed the service, not the number assigned by the health plan. For HIPAA, the maximum length of the field is 20 characters.
Required	2300	CLM	CLM02	Total Claim Charge Amount	The total amount of all submitted charges of service segments for the claim		The sum of all encounter line billed amounts

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required	2300	CLM	CLM05-1	Facility Type Code	Code identifying the type of facility where services were performed; the first and second positions of the Uniform Bill Type code or the Place of Service code from the Electronic Media Claims National Standard Format		The first two characters of the UB Type of Bill field on institutional encounters.
Required when encounter submission is untimely otherwise not used	2300	CLM	CLM05-3	Claim Frequency Code	Code specifying the frequency of the claim. This is the third position of the Uniform Billing Claim Form Bill Type.	7 8 Other Values	Replacement (Replacement of prior claim) Void (Void/Cancel of prior claim) Original Claim The Claim Frequency Code is the third character of the UB Type of Bill field on institutional encounters.
Required	2300	CLM	CLM20	Delay Reason Code	Code indicating the reason why delayed	1 2 3 4 5 6 7 8 9 10 11	Proof of Eligibility Unknown or Unavailable Litigation Authorization Delays Delay in Certifying Provider Delay in Supplying Billing Forms Delay in Delivery of Custom-made Appliances Third Party Processing Delay Delay in Eligibility Determination Original Claim Rejected or Denied Due to a Reason Unrelated to the Billing Limitation Rules Administration Delay in the Prior Approval Process Other This data element can be entered when an encounter is submitted late (after the contracted of filing requirement). If the reason for the delay is not specified in the list, enter “11” (Other).
Required	2300	DTP	DTP01	Date/Time Qualifier	Code specifying type of date or time, or both date and time	096	Discharge
Required	2300	DTP	DTP03	Discharge Hour Date Time Period	Expression of time; required on all final inpatient claims		Discharge Hour expressed as HHMM
Required	2300	DTP	DTP01	Date/Time Qualifier	Code specifying type of date or time, or both date and time	434	Statement

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required	2300	DTP	DTP03	Statement Date Date Time Period	Expression of date or range of dates when service occurred		Begin and End Dates of Service
Required	2300	DTP	DTP01	Date/Time Qualifier	Code specifying type of date or time, or both date and time	435	Admission
Required	2300	DTP	DTP03	Admission Date/Hour Date Time Period	Expression of date and time; required on all inpatient claims		Admission Date and Hour
Required on Inpatient	2300	CL1	CL102	Admission Source Code	Code indicating the source of the admission		Admission Source
Required on Inpatient	2300	CL1	CL103	Patient Status Code	Code indicating the patient status as of the statement covers through date		Patient Status
Required for all but fee-for-service payment arrangements	2300	CN1	CN101	Contract Type Code	Code identifying a contract type	01 02 03 04 05 06 09	Diagnosis Related Group (DRG) Per Diem Variable Per Diem Flat Capitated Percent Other Enter the value that best describes the facility's relationship to the health plan.
Required for voids or replacements	2300	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number This REF Segment is required on replacement and void claims. The Original Reference Number is the AHCCCS CRN assigned to the encounter being replaced or voided (when CLM05-3 = "7" or "8").
Required for voids or replacements	2300	REF	REF02	Claim Original Reference Number	Number assigned by a processor to identify a claim		The AHCCCS assigned Claim Reference Number (CRN) for the encounter being replaced or voided.

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Situational, may be reported	2300	REF	REF01	Reference Identification Qualifier	Code qualifying the Reference Identification	EA	Medical Record Number
Required for Inpatient and Outpatient services	2300	REF	REF02	Medical Record Number Reference Identification	Medical record number		The Medical Record Number assigned to the AHCCCS recipient by the servicing organization
Required	2300	HI	HI01-1	Code List Qualifier Code	Code identifying a specific industry code list.	BK	Principal Diagnosis
Required	2300	HI	HI01-2	Principal Diagnosis Code	Health care industry code indicating reason for the visit		Principal Diagnosis Code
Required, if present on original claim from provider	2300	HI	HI02-1	Code List Qualifier Code	Code identifying a specific industry code list.	BJ	Admitting Diagnosis
Required, if present on original claim from provider	2300	HI	HI02-2	Admitting Diagnosis Code	Health care industry code indicating reason for the visit		Admitting Diagnosis Code
Required, if present on original claim from provider	2300	HI	HI03-1	Code List Qualifier Code	Code identifying a specific industry code list.	BN	E-code
Required, if present on original claim from provider	2300	HI	HI03-2	E-code Diagnosis Codes	Health care industry code indicating reason for the visit		E-code Diagnosis Codes
Required when other diagnosis codes are known	2300	HI	HI01-1	Code List Qualifier Code	Code identifying a specific industry code list.	BF	Other Diagnosis
Required when other diagnosis codes are present on original claim from provider	2300	HI	HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2, HI09-2, HI10-2, HI11-2, HI12-2	Other Diagnosis Information Code	Health care industry code indicating other conditions co-existing with the principal diagnosis		Other Diagnosis Codes that co-exist with the principal diagnosis, co-exist at the time of admission or develops subsequently during recipient's treatment The 837I allows for 2 Other Diagnosis Information segments for a total of 24 other diagnosis codes per claim.

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required when procedure is performed	2300	HI	HI01-1	Code List Qualifier Code	Code identifying a specific industry code list.	BP BR	HCPCS ICD-9-CM
Required when procedure is performed	2300	HI	HI01-2	Principal Procedure Code	Code indicating a procedure was performed during the stay		The Principal Procedure performed during this encounter statement period
Required when procedure is performed	2300	HI	HI01-3	Date Time Period Format Qualifier	Code indicating the date format, time format or date and time format.	D8	Use code D8 when the value in composite data element HI01-1 equals “BR”.
Required when procedure is reported	2300	HI	HI01-4	Principal Procedure Date Date Time Period	Expression of date when the procedure was performed		The Principal Procedure Date. Date Expressed in Format CCYYMMDD.
Required when procedure is performed	2300	HI	HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08-2, HI09-2, HI10-2, HI11-2, HI12-2	Other Procedure Information Industry Code	Code indicating additional procedures performed during the stay		Other Procedures performed The 837I allows for 2 Other Procedure Information segments for a total of 24 Procedure, Dates and Times per claim.
Required when procedure is performed	2300	HI	HI01-3	Date Time Period Format Qualifier	Code indicating the date format, time format or date and time format.	D8	Use code D8 when the value in composite data element HI01-1 equals “BR”.
Required when procedure is reported	2300	HI	HI01-4, HI02-4, HI03-4, HI04-4, HI05-4, HI06-4, HI07-4, HI08-4, HI09-4, HI10-4, HI11-4, HI12-4	Other Procedure Date Date Time Period	Expression of date when the procedure was performed		Other Procedure Dates Dates Expressed in Format CCYYMMDD.
Required if not billing or pay-to provider otherwise not used	2310E	NM1	NM109	Service Facility Primary Identifier	Primary identification for the service provider		The Service Provider’s EIN, SSN or NPI

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required if not billing or pay-to provider otherwise not used	2310E	REF	REF02	Service Facility Secondary Identifier	Secondary identification for the service provider		The Service Provider's 6-digit AHCCCS Provider ID and 2-digit Location Code
Required	2320	SBR	SBR01	Payer Responsibility Sequence Number Code	Code identifying the insurance carrier's level of responsibility for a payment of a claim	P or S or T	Primary or Secondary or Tertiary The SBR Other Subscriber Information Loop can occur up to ten times for up to ten payers other than AHCCCS. One iteration of the loop is always for the individual health plan that submits the encounter. SBR Loops in addition to the health plan loop are for payers other than the member's health plan. They can have any responsibility sequence and may be for subscribers other than the health plan member (e.g., family members). Note that the 2320 Loop is an "umbrella loop" that contains within it Loops 2330A through 2330E. All of these loops can be repeated as needed for each payer.
Required if different from claim level	2320	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	CO CR OA PI PR	Contractual Obligations Correction and Reversals Other Adjustments Payer Initiated Reductions Patient Responsibility Enter the code value that best describes the reason for the different between the Charged Amount and the Paid Amount for this service line. This CAS Segment is used only when an adjustment or payment is at the service line level. The "Adjustment Trio" of Adjustment Reason, Amount, and Quantity can occur up to six times per CAS Segment and CAS Segments have up to 99 iterations per service line.

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required only if not reported at service line and if claim level charges/units not fully paid	2320	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	Many Code Set Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company's Web Site (www.wpc-edi.com). Enter the code value that best describes the reason for the difference between the Charged Amount and the Paid Amount. These are the same Adjustment Reason Codes that appear on the 835 Claim Remittance Advice Transaction. The 837 Transaction is designed to pick them up from the other payer's 835. If a health plan transmits 835 Remittance Advice Transactions to providers, data from these transactions can be the source of the Adjustment Reason Code(s) on the initial health plan iteration of the 2320 Loop. For subsequent other carriers, the Adjustment Reason Code(s) can be transferred (or generated by the health plan) if available.
Required only if not reported at service line and if claim level charges/units not fully paid	2320	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		The difference between the claim level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02.
Required only if not reported at service line and if claim level charges/units not fully paid	2320	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		The difference between the billed and paid units of service for all service lines when the difference is the result of claim level adjudication and is associated with the Adjustment Reason Code in CAS02.
Required	2320	AMT	AMT01	Payer Prior Payment	Code qualifying the COB Payer Prior Payment	C4	Amount the payer has paid to the provider towards this claim.
Required (zero is allowed for capitated services)	2320	AMT	AMT02	Other Payer Patient Paid Amount	The amount this payer has paid to the provider towards this bill.		On health plan 2320 COB Loops, this element is for the Health Plan Paid Amount. For other carriers, it is the amount paid to the provider by that carrier.
Required	2320	AMT	AMT01	COB Allowed Amount Qualifier	Code qualifying the COB Allowed Amount	B6	The encounter level Allowed Amount for the payer of this 2320 Loop.

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required (zero is not permitted)	2320	AMT	AMT02	COB Allowed Amount	The maximum amount determined by the payer as being 'allowable' under the provisions of the contract prior to the determination of actual payment		The encounter level Allowed Amount for the payer of this 2320 Loop. For health plan 2320 Loops, the Allowed Amount is always greater than zero.
Required when greater than zero	2320	AMT	AMT01	COB Total Amount Qualifier Code	Code to qualify amount	A8	Noncovered Charges - Actual
Required when available	2320	MOA	MOA01	Reimbursement Rate	Rate used when payment is based upon a percentage of applicable charges		The Medicare Outpatient Adjudication MOA Segment is required if data for it is available from an electronic remittance advice (835 Transaction). This segment is used for outpatient adjudication Information, including standard HIPAA Remark Codes generated by Medicare or another carrier. The MIA Segment carries similar data, including Remark Codes, for inpatient encounters. All data elements within both MIA and MOA Segments are situational. They will reflect adjudication by Medicare or another payer and should be included if available to the health plan. The MOA01 element carries the payer's Reimbursement Rate if payment is based on a percentage.
Required	2330A	NM1	NM109	Other Insured Identifier	An identification number, assigned by the third party payer, to identify the additional insured individual		In the health plan 2320 Loop, the member's AHCCCS ID. In subsequent 2320 Loops, the Subscriber ID assigned by the other payer.
Required	2330B	NM1	NM108	Identification Code Qualifier	Code designating the system/method of code structure used for Identification Code	PI	Payer identification
Required	2330B	NM1	NM109	Other Payer Primary Identifier	An identification number for the other payer		In the health plan 2320 Loop, this identifies the health plan's AHCCCS ID, TSN, and Input Mode. In subsequent 2320 Loops, any identification number assigned to the other payer.
Required	2330B	REF	REF01	Reference Identification Qualifier	Code qualifying the reference identification	F8	Original Reference Number Use code F8 to indicate the payer's claim number assigned to this claim by the health plan or other payer referenced in this iteration of Loop 2330B.

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required	2330B	REF	REF02	Other Payer Secondary Identifier	Additional identifier for the other payer organization		The health plan's or other carrier's claim control number for the claim the resulted in this encounter. This is not the CRN that AHCCCS assigns to the encounter.
Required	2400	LX	LX01	Service Line Assigned Number	Service line number that functions as a line counter		Line Counter
Required	2400	SV2	SV201	Service Line Revenue Code	Identifying code for institutional product or service		Revenue Code
Required	2400	SV2	SV202-1	Product or Service ID Qualifier	Code identifying the type/source of the descriptive number used in Product/Service ID		One or more HCPCS Procedure Code is required for all outpatient institutional encounters. A service line procedure can also be included on inpatient encounters if applicable.
Required when Outpatient service and HCPCS exists for service	2400	SV2	SV202-2	Procedure Code	Identifying number for product or service		HCPCS Procedure Code
Required when special performance circumstance related to HCPCS	2400	SV2	SV202-3 SV202-4 SV202-5 SV202-6	HCPCS Modifier	Identifies special circumstances related to the performance of the service		HCPCS Modifier
Required	2400	SV2	SV203	Line Item Charge Amount	Charges by revenue code category		Provider's Service Line Charged Amount
Required	2400	SV2	SV205	Service Line Unit Count	Numeric value of quantity		Provider's Service Line Units
Required when revenue code is 100-219	2400	SV2	SV206	Service Line Rate	The rate per unit of associate revenue code		Service Line Rate Amount

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required when reporting specific non-covered charge amount	2400	SV2	SV207	Line Item Denied or Non-Covered Charge Amount	Monetary Amount		Service Line Non-Covered Charge Amount
Required on Outpatient	2400	DTP	DTP01	Service Line Date Date/Time Qualifier	Date/Time Qualifier	472	Service
Required on Outpatient	2400	DTP	DTP02	Date Time Period Format Qualifier	Code indicating the date format, time format, or date and time format.	D8 RD8	Date Expressed in Format CCYYMMDD Range of Dates Expressed in Format CCYYMMDD-CCYYMMDD
Required on Outpatient	2400	DTP	DTP03	Service Line Date Date Time Period	Expression of date or range of dates indicating when service occurred		Service Line Begin and End Dates of Service
Required if not reported at the Claim Level	2430	SVD	SVD01	Payer Identifier	Number identifying the payer organization		The 2430 Service Line Adjudication Information Loop is required if the claim that resulted in this encounter had been previously adjudicated by a payer identified in Other Payer Name Loop 2330B and this service line has adjustments (differences between charged and paid amounts) applied to it. There is no HIPAA standard for the payer identifier. For AHCCCS encounters, it must match a payer identifier in an Other Payer Name 2330B Loop. For health plan payers, SVD01, if present, should carry the same AHCCCS Health Plan ID, TSN, and Input Mode as NM109 in Loop 2330B. For subsequent other payer Loops, use available Payer ID Numbers and names.
Required if not reported at the Claim Level	2430	SVD	SVD02	Service Line Paid Amount	Amount paid by the indicated payer for a service line		This is the Health Plan Paid Amount at the service line level.

837 INSTITUTIONAL ENCOUNTER TRANSACTION SPECIFICATIONS							
AHCCCS Usage	**Loop ID**	**Seg ID**	**Element ID**	**Element Name**	**Element Definition**	**Valid Values**	**Definition/Format**
Required if not reported at the Claim Level	2430	CAS	CAS01	Claim Adjustment Group Code	Code identifying the general category of payment adjustment	CO CR OA PI PR	Contractual Obligations Correction and Reversals Other Adjustments Payer Initiated Reductions Patient Responsibility Enter the code value that best describes the reason for the different between the Charged Amount and the Paid Amount for this service line. This CAS Segment is used only when an adjustment or payment is at the service line level. The “Adjustment Trio” of Adjustment Reason, Amount, and Quantity can occur up to six times per CAS Segment and CAS Segments have up to 99 iterations per service line.
Required if not reported at the Claim Level	2430	CAS	CAS02	Adjustment Reason Code	Code that indicates the reason for the adjustment	Many Code Values	Hundreds of Adjustment Reason Code values are maintained on the Washington Publishing Company’s Web Site (www.wpc-edi.com). Enter the code value that best describes the reason for the difference between the Charged Amount and the Paid Amount.
Required if not reported at the Claim Level	2430	CAS	CAS03	Adjustment Amount	Adjustment amount for the associated reason code		The difference between the service line level Charged Amount and Paid Amount associated with the Adjustment Reason Code in CAS02.
Required if not reported at the Claim Level	2430	CAS	CAS04	Adjustment Quantity	Numeric quantity associated with the related reason code for coordination of benefits		The difference between the billed and paid units of service when the difference is the result of line level adjudication and is associated with the Adjustment Reason Code in CAS02.

Appendix A: Electronic Data Interchange Documents

A.1 Form 1: Health Plan/Program Contractor Encounter Submission Notification and Transmission Submitter Number (TSN) Application

Overview

This form provides notice to the encounter unit of the designated person authorized to submit and receive encounter data and related information from AHCCCSA. It also furnishes an estimate of monthly encounters to be reported by the contractor. Contractors must complete this notification form before testing and submitting encounter data to AHCCCSA.

Upon receipt of this form, a TSN is issued. The TSN allows AHCCCS to identify the contractor identification numbers and county codes for which that transmission submitter is authorized to submit encounters.

Field No.	Instructions
1.	Enter the name of the contractor.
2.	Enter the contractor's ID number assigned by AHCCCSA.
3.	Enter the date the contractor will begin submitting encounters to AHCCCSA.
4-8	Enter the contractor's complete address and telephone number, and encounter contact person and contact person's telephone number
9-12	Monthly estimate of volumes for 837P (Form A), 837D (Form D), 837I (Form B) and NCPD (Form C) encounters that will be submitted to AHCCCSA.
13	Enter the name of the person authorized to send and receive encounter data (may be an employee of the contractor or an employee of a subcontracted vendor).
14.	Type or print the CEO/Administrator's name.
15.	Enter the date the form is signed.
16.	Signature of the CEO/Administrator.

701 East Jefferson, Mail Drop 6500, Phoenix, Arizona 85034

Health Plan/Program Contractors Encounter Submission Notification And Transmission Submitter Number (TSN) Application

In order to submit encounter data to AHCCCS, Health Plans/Program Contractors (Contractors) must be assigned a Transmission Submitter Number (TSN). To apply for your contractor TSN, please complete this application and forward to the encounter unit.

Health Plan/Program Contractor Name:	**Number:**
1.	**2.**

As representative for the above Health Plan/Program Contractor (Contractor), I hereby notify the encounter manager of the AHCCCS Administration that the contractor's encounter submission will start on **____/ 3. /___.** The contractor named above agrees to submit all encounter data, and correct any encounter submission errors within the limited time frame prescribed by the AHCCCS Administration.

Contractor Address: (Street) **4.**
(City, State & Zip Code) **5.**
Contractor Telephone Number: **6.**
Contact Person's Name: **7.**
Contact Person's Telephone Number: **8.**

Contractor estimates that the monthly average encounter submission volume will be as follows:

837P (Form A) Encounters: **9.**
837D (Form D) Encounters: **10.**
837I (Form B) Encounters: **11.**
NCPD (Form C) Encounters: **12.**

Contractor requests that encounter related files/reports from the AHCCCS Administration be made available to: **13.**

CEO/Administrator: **14.** Date: **15.**

Signature: **16.**

A.2 Form 2: Electronic Data Interchange Agreement Form

Overview

The Electronic Data Interchange (EDI) Agreement Form is a contract between the contractor and AHCCCSA, which authorizes AHCCCSA to accept, encounter data submitted via EDI. The contract also holds the contractor responsible for submitting this data in accordance with applicable rules and regulations, and within file specifications.

Field No.	Instructions
1.	Enter the name of the contractor.
2.	Enter the contractor's ID number assigned by AHCCCSA.
3.	Type or print the CEO/Administrator's name.
4.	Enter the date the form is signed.
5.	Signature of the CEO/Administrator.

Arizona Health Care Cost Containment System
701 E. Jefferson, Mail Drop 6500, Phoenix, Arizona 85034

Electronic Data Interchange Agreement Form

1. (Health Plan/Program Contractor, herein called "Contractor") is hereby authorized to submit encounter data to the Arizona Health Care Cost Containment System Administration (herein called "AHCCCSA") for services rendered by the undersigned contractor, in machine-readable form, as specified by AHCCCSA. The contractor certifies that the encounter data so recorded and submitted as input data are in accordance with all procedures, rules, regulations and statutes now in effect. If any of those procedures, rules, regulations or statutes is hereafter amended, the contractor agrees to conform to those amendments of which contractor has been notified. Contractor further certifies that it will retain and preserve all original documents as required by law, submit all or any part of same, or permit access to same for audit purposes, as required by the State of Arizona, or any agency of the federal government, or their representatives.

In consideration of AHCCCSA's acceptance of the contractor's input data, the contractor agrees to be responsible for any incorrect or delayed payments made to the contractor as a result of any error, omission, deletion, or erroneous insert caused by the contractor in the submitted input data. In the event of any inconsistencies between the input data and underlying source documents, whether set forth in encounter forms or otherwise, AHCCCSA shall rely on the input data only.

The contractor further agrees to hold AHCCCSA harmless from any and all claims of liability (including but not limited to consequential damages, reimbursement of erroneous billings and reimbursement of attorney fees) incurred as a consequence of any such error, omission, deletion, or erroneous input data. AHCCCSA shall not be responsible for any incorrect or delayed payments to the contractor resulting from any error, omission, deletion or erroneous input data that does not meet the standards prescribed by AHCCCSA. Erroneous encounter input data shall be returned to the contractor for correction and resubmission, within the limited time frame prescribed by AHCCCSA, at the contractor's cost.

The contractor herewith authorizes AHCCCSA to (1) make administrative corrections on submitted encounter data to enable the automated processing of the same; and (2) accept original evidence of services rendered and encounter data in a form appropriate for automated data processing.

The contractor agrees and certifies that the contractor's certification appearing on all encounter forms in use as of a given submission date are incorporated by reference in this agreement, shall remain valid and applicable to all encounter data submitted, and herewith are adopted by the contractor as though individually executed. Additionally, contractor certifies that based on best knowledge, information, and belief all data submitted to AHCCCSA will be accurate, complete, and truthful.

Contractor Number: **2.**

CEO/Administrator: **3.** Date: **/ 4./**

Signature: **5.**

A.3 Form 3: Data Certification Email

Overview

The Data Certification Email certified by the Chief Executive Officer, Chief Financial Officer, or an individual who has delegated authority to sign for, and who reports directly to Chief Executive Officer or Chief Financial Officer, must attest, based on best knowledge, information, and belief, that data is complete, accurate, and truthful and complies with 42 CFR Sections 438.604 and 438.608. Contractor is responsible for submitting this data in accordance with applicable Federal and State laws, rules, policies and the AHCCCSA contractor contract and within file specifications. The Data Certification Email must be submitted concurrently with the certified data and must be matched to contractor's file or document prior to file or document processing or use.

	Instructions
1.	Email must be sent to: bba@ahcccs.state.az.us
2.	Email must be sent from person, e.g. CEO, CFO, or direct report to CEO or CFO, authorizing the data.
3.	Subject line must contain the filename, total bill charge, and the claim count in the file. These topics must be followed by an '=' sign. Total bill charges must have a single space between the words. The order of these within the subject line does not matter, however abbreviations are not allowed. Always send a new email to certify files.
4.	There are four potential responses to Data Certification Email: 1. Data Certification was received from an unauthorized email address; 2. File, based on filename in subject line, was not found; 3. Total bill charge or count in subject line does not match total bill charge or count in the file; and 4. Valid file was found and will be processed.
5.	A daily report will be emailed with a list of files that have not yet been authorized. Files that have not been matched to Data Certification Email for a period of 10 days will be deleted.
6.	The body of the email must have the same text as in the example below. Data Certification Email without or with incomplete contents of the body will not be used to certify files.

Arizona Health Care Cost Containment System
bba@ahcccs.state.az.us

Data Certification Email

TO: bba@ahcccs.state.az.us

Subject: filename=AZSTNDPLANIDTSNXMMDDYY.SEQ count=123 total bill charges=987

Health Plan/Program Contractor/ADHS/DBHS, herein called "Contractor" is hereby authorized to submit encounter data to the Arizona Health Care Cost Containment System Administration (herein called "AHCCCSA") for services rendered by the contractor, in machine-readable form, as specified by AHCCCSA.

By submission of this email, I certify that the data and/or documents so recorded and submitted as input data or information, based on my best knowledge, information, and belief, is in compliance with Subpart H of the Balanced Budget Act Certification requirements; is complete, accurate, and truthful; and is in accordance with all Federal and State laws, regulations, policies and the AHCCCSA/Contractor contract now in effect. Contractor further certifies that it will retain and preserve all original documents as required by law, submit all or any part of same, or permit access to same for audit purposes, as required by the State of Arizona, or any agency of the federal government, or their representatives.